				1 - For State Registrar	State	of Maryla		artmen		Health and Death	Mental Hy	/giene Reg. No.	006		120	01
				Decedent's Name (First, Middle, L.	ast)						2. Date of D	eath			3. Time o	of Death
		Physici		Phy11is	. Bra	dfield	Но1	tkamp			March	30	200		12:27	7 P. ^M
		/Medic Examir		4a. Fecility Name (If not institution, g					Town, a	or Location of Deal			County of De			
				Shady Grove Adve	ntist H	lospital		Roo	ckvi	ille			Montg	ome	ry	
		Funeral			Sex		. last birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		irth				or Foreign
	Ю	Director		327-20-0094	1 □ M 2 🔼 F	8	2 Yrs.	Worth	Days	Tiodis imit	July 1	5, 19	23 I	11 i	nois	
		pu k		Usual Residence of Decedent 10a, State 10b, County		100.0	ity, Town or Lo	cation						10	d Incide (City Limits
		eho e	2			100.0								10		s 2 X No
2		the M	Director	Maryland Montgon	nery		Gaithe	rsbur;				10a Citia	en of What			
to HKamp	>	filed within 72 hours after deeth with the Maryland Hygiene. yther than "naturel", or tleme 23a or 28a-1 ehow ant, the Madical Examiner must be notified at	급		1.0.1					-					•	
~		99th	erai	8907 North West1		ve cedent Ever in	12 12		087		Spoothy Von or N		ited S			
12		ter d	Funeral	1 ☐ Never Married 2 ☐ Married	Armed F	orces?	0.0.	If Yes, spec	rfy Cubi	dispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	0-	Black, W			
F	38	urs af	by	3₺ Widowed 4 Divorced	If Yes, G Year or	ive		1 ☐ Yes 2	ZX No	Specify:			Specify:	Whi	to	
0	5-0036	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usua	I Occup	pation	7.61	16b. Kir	d of Busine			
7	215	hin 7	ple	(Specify only highest g Elementary/Secondary (0-12)		(1-4or5+)	(Give	kind of wor DO NOT us	rk done se retire	during most of wo d)	rking					
700	21	d with	Completed	Clamariary/ occorridary (o 12)	2	(1.401.01)	S	ecret	ary			Ind	ıstria	1 1	lachi	nes
		e file al Hy oth	Be (17. Father's Name (First, Middle, Las	st)					18. Mother's Na	me (First, Middle	a, Maiden .	Sumame)			
S	/lai	uld b Ventz rked	70.	Albert		Laur	ence				France	es	S	war	son	
Phylli	Maryland	jes 1 end 2 should be filed within 7 of Heelth and Mental Hygiene. If item 27 is marked other than "n other treumatic event, the Madi		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Number or R	ural Route Numb	oer, City or	Town, State	, Zip (Code)	
7		permit. Pages 1 end 2 Depertment of Heelth a Important: If Item 27 It any injury or other tre ance.		John G. Bradfiel	d/Son					e Court,		sbur	, Mar	y1a	ind 2	0877
Ž	altimore,	T ite		20a. Method of Disposition 1 ☐ Burial 2∑ Cremation 3	□ Bemoval from	4	Place of Dispo cemetery, cres	sition (Nan natory or of	ne of ther plac	сө)	Date	20c. Loc	ation - City	or Tov	m, State	
9	Ĕ	Pages ment of hand of hand of hand of hand of hand or of		4 Donation 5 Other (Spec			tropoli	tan C	rema	atory 3/	31/2006	Alexa	andria	, ,	irgi	nia
	alt	permit. Depertn imports any inju		21 Supature of Funeral Service Lic	ensee	20	22	2. Name an	d Addre	ess of Facility De	Vol Fune	eral E	Iome			
	8	40 = 40		Veclen	() low	July -	10	East	De	er Park 1	Dr., Gai	thers	burg,	MI	. 20	877
				23a. Part 1. Enter the disease, or co- shock, or heart failure. List only	mplications that y one cause on	caused the dea	ath. Do not ent	er the mode	e of dyir	ng, such as cardia	c or respiratory a	arrest,			Approxima Interval Be	etween
4	1	Physician		Immediate Cause (Final disease or condition	Pneur	nonia									Onset and	
•	1	/Medical		resulting in death)	Due to	(or as a conse	quence of):									
		Examiner		Sequentially list conditions.	b											
		D 15	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):									
		and trans	ram	that initiated events resulting in death) Last	c									1		
	60,	cete be executed obysicien and the burial-transit		Toolating in additify cast	Due to	(or as a conse	quence or):									
	8760,	cete be executed obysicien and the burial-transit	dlcal	•	d						*			-		
	9 ×	Physicien: The law requires that the death certific this certificete has been signed by the attending p rai director, page 2 should be detached for use as:	by Physician/Me	IF FEMALE:	230 Haves of	utcome of pregr	22001									
	Вох	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 ☐ Fet gnant at time of	al death 3	Ectopic pre		y		2	3d. Date of one of the		y Day	Year
	P.O.	the de	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unki		death 5	Other (spe	өспу)							
	٦	that the deed by the	F.	Part II. Other significant conditions	contributing to	death but not re	sulting in the u	nderlying ca	ause div	ren in Part I.	23e. Did	tobacco us	se contribute	to the	cause of	death?
	of Vital Records,	sign d be	ďρ	_	· ·]No 3□			
	Ö	w requir been si should	Completed								24a. Was		0.00	1		
	Rec	has has	d H								auto		24b. Were prior t death	autop o com	pletion of	cause of
	a	icien: The l certificete ha rector, pege					-				1 ☐ Yes	2 🔯 No			!□ No	
	Σ̈́	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	Hospital:		7		Oth		ath Check only					
	of	Phys rthis raldi	- T	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of			er: 4 ☐ Nursing F	dome 5 ☐ Res 28d. Describe			oecify)		
	O	ding Ph th. : After th funeral	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigate	(Mo	nth, Day Year)	Injury	м	8c. Injur Wor	rk? Yes 2 ∐No		, , ,				
	Division	Attendi death. octor: A by the fu	fica	3 ☐ Suicide 6 ☐ Could not	be gas Blas	e of Injury - At I	home, farm, str				28f. Location	(Street and	Number or	Rural	Route Nu	mber.
	Ď	after Dire	Certification;	4 Homicide	u build	ding, etc. (Spec	ily)	,			City or To	wп, State)				
		To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		(Check only 21 Madical Ext	miner: On the	basis of examin	owledge, deatl	n occurred a	at the tin	me, date and place	and due to the urred at the time.	cause(s) a	and manner	as sta	ted. he cause((s)
		thin 2 the mplet	Medical	29b. Signature and title of dertifier	and ma	nner stated.				e number			signed (Mo			
		₹ <u>₹ 8</u>		M. 1/	- 1							11	j ~	ر در	ا ا	• 6
				20 110/12		SICIAN			006	3088		Mar	ch S	0	, 200	26
		12		Mohit Rustoa:				•	. D.	., Rockv	4112 20	n 20	Q5A			
		Sta	te	31. Date filed (Month, Day, Year)		9901 Me Registrar's Sign		enter	בע ב	., KUCKV	ттте, М	J. 20	0.00			
		Registr		APR 04	2006		1 A	marke	7							

Registrar

Registrar

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			1 - For State Registrar		State o	f Mary	land / Depa <i>Ce</i> a	artment o rtificate			Mental Hy	ygien Reg. Ni	UU	6	12004
I	Physici		1. Decedent's Name June			Потго					2. Date of D Month	Da		Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If	Virgin		Haye	8	4b. City. Toy	wn. or L	ocation of Death	March		c. County o	006 f Death	1:35 A M
	CXamili	lei		ingswood			ter			ville			Mont		P17
-	Funeral		5. Social Security Nu				yrs. last birthday)	If Under 1 Y	/ear	If Under 24 Hrs.	8. Date of B	irth	MOIIL	9. Birtho	lace (State or Foreign
	Director		216-80-943	36	⊐м 2 ∏ F	8	39 Yrs.	Months D	ays	Hours Min.	8. Date of B (Month, D June	30,1	916	Coun Wash	ington D.C
H	ס		Usuel Residence of D	Decedent				· · · · · · · · · · · · · · · · · · ·			1				
	rylan how		10a. State	10b. County		100	c. City, Town or Lo	ocation						1	0d. Inside City Limits
	e Ma	cto	MD	Montgo	mery		G	aithers	sbur	'g					1 ☐ Yes 2 No
	5 th)Ire	10e. Street and Num					10f. Zip Co	ode			10g. C	itizen of W	hat Cour	ntry?
	23e	aic	109 Roll	ling Road						20877		U	Inited	l Sta	ates
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f show eny injury or other treumatic event, it a Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed 4	_	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Gin Year or D	rces? 2 [XNo ve	1	Was Decedent If Yes, specify 1 ☐ Yes 203		panic Origin? (Si Mexican, Puerto Specify:	pecify Yes or N o Rican, etc.)	lo-		, White,	ean Indian, etc. nite
	2 ho	ted	(Con sit	15. Decedent's Edu	ucation		16a. Dece	dent's Usual C	ccupati	ion	tion a	16b. l	Kind of Bus	iness/Inc	dustry
í	hin 7	Completed	Elementary/Second	fy only highest grad	College (1-4or 5+)	life.	DO NOT use r	etired)	ring most of wor	king				
1	d wil	ПO	12					Homema	ker				Own H	lome	
2	e file ai Hy oth	Be (17. Father's Name (F	First, Middle, Last)					1	8. Mother's Nam	ne (First, Middle	e, Maide	n Sumame)	
3	Aenta Aenta Irked	To	Maynard	Hoy1e						Martha	Magru	der			
5	and ham		19a. Informant's Nan	me/Relationship (7)	ype, Print)					d Number or Ru					,
2	and 2 alth alth or tre		P. Steven	Hayes /	Son					Tune Dr	rive, G	erma	ntown	, MI	20876
	Pages 1 and of He			osition Cremation 3 🗆 I 5 🗋 Other (Specify)		Otato	Ob. Place of Dispo cemetery, cree Forest O			, 1 287	Date 11 3 06		ocation - C		own, State
	permit. Depertmine imports eny inju		21. Signature of Fund	eral Service Licens	600 -)	22	2. Name and A	ddress	of Facility De	eVol Fu	nera sbur	1 Hom	e, 1	0 East
	Physician /Medical Examiner	er	23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death) Sequentially list con-	inal	a. Cor	ngest: (orasaco conary	ive Heart nsequence of): y Artery nsequence of):	Failu	re	such as cardiac	or respiratory	arrest,			Approximate Intervat Between Onset and Death 60 Days
5	icate be executed physicien and s the burial-transit	edical Examine	Sequentially list confiancy, leading to imn cause. Enter Under Cause (Disease or in that initiated events resulting in death) La		c. Adv	ance	d Dementi	La							
5		Med	IF FEMALE:												
	The law requires that the death certi ate has been signed by the attending paga 2 should be detached for use a	Physician/M	23b. Was decedent print the past 12 mm 1 Yes 2 9 Unknown	nonths?		ointh 2 🗋 nan1 al time	Fetal death 3	Ectopic pregr Other (specif					23d. Date Mont		ory Day Year
	res that igned b be deta		Part II. Other signific	cant conditions co	ntributing to d	eath but no	t resulting in the u	nderlying caus	e given	in Part I.	23e. Did	tobacco	use contrib	oute to th	ne cause of death?
3	uires sigr ld be	d by	Sepsis								10	Yes 2	2□No 3	Prob	ably 4 Hunknown
5	w requi	ete	Periin	heral Vas	coular	Dicos	200				24- 116		045 144		
	ysicion: The lav is certificate has director, paga 2:	Completed			SCUIAL	DISEC	150				24a. Wa: auto perf 1 🗆 Yes	opsy formed?	de	or to coreath?	psy findings available mpletion of cause of 2 No
	certif recto	Be	25. Was case referre examiner?	1	Hospital:				Other:	26. Place of Dea					
5	Phys this al di	2	1 ☐ Yes 2 🛣N 27. Manner of Death	10	28a. Date	•	2 ER/Outpatier			4 (X Nursing H					y)
	the Hospitel or Attending Physicien: nin 24 hours elter death. the Funerel Director: Atter this certifics inpletely filled in by the funeral director, is	Certification;	1 XNatural 2 Accident 3 Suicide	5 Pending investigation 6 Could not be	(Mon	th, Day Yea	ar) 28b. Time of Injury At home, farm, str	М		es 2 No	28d. Describe				l Route Number,
5	pitel or A urs efter brei Dire	Certif	4 Homicide	determined	buildi	ng, etc. (S)	pecify)				City or To	own, Stat	re)		
	To the Hospitel or Attendi within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	fedical	one)	Cartifying Phy	mar: On the b	best of my asis of exa ner stated.	y knowledge, deatl mination and/or in	vestigation, in	my opir	nion, death occur	, and due to the rred at the time	, date an	nd place, ar	nd due to	the cause(s)
	To with	Σ	29b. Signature and to	E SS	M		CM		OC		35		3/2		
	10		30. Name and address	ss of person who o	1500	430	1 971	Print) Mc	di	(2) (en	ie Dr.	Ro	ctul	lle	2006 M) 70856
	Sta Registr		31. Date filed (Manual)	Pay, Year) 4 20	006	legistrar's S	Signature	artis							•

		_	For State Registrar		e of Ma	aryland		artmen rtificate				lental Hy	Reg. No		5	120	05
В	Physici	an	Decedent's Name (First, Middle	, Last)								2. Date of D Month		ž006 `	Year	3. Time	
	/Medic	al .	David			KAVY		41- Cit.	Town or	Leastion	of Donth	April	-	. County of	f Dooth	4:4	5 A.M
	Examin	er	4a. Facility Name (If not institution National Luthe	r, give street ar ran Hor	nd number) n e			4b. City,	ckv1	IIe	or Death		40	Mont		rv	
			5. Social Security Number	6. Sex	7. Age	e (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of B	irth .		9. Birthp	ace (State	or Foreign
	Funeral Director		058-10-0124	1 ₹ M 2		93	Yrs.	Months	Days	Hours	Min.	July	30,	1912	New	York	
			Usual Residence of Decedent														0: 1: 1:
	anylar show	_	MD MOntgo	mer:		,	, Town or La ockvil									0d. Inside (s 2 No
	889-f	Director						-	Codo				10a C	itizen of Wh	nat Cour	A	
	with t	D	10e. Street and Number 1916 Dundee	Poed				10f. Zip	20850)			Tog. C		S.A.	uy:	
	leath	Funerai	11. Marital Status	12. Was	Decedent I	Ever in U.S	S. 13.	Was Deced	dent of His	spanic Or	igin? (Spe	ecify Yes or N	0-	14. Race	- Americ		
(0	r iter	Fun	1 ☐ Never Married 2 ☐ Mar	ied 1 🗌	ed Forces?	No			-			Rican, etc.)			, White,		
ğ	rat', o	by	3 X Widowed 4 □ Divorced	Yea	s, Give r or Dates:			1 ☐ Yes :	X	Specify				Specify:	Whit	e	
2	72 h	Completed	15. Deceder (Specify only highe	t's Education st grade compl	eted)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ition <i>Juring m</i> os	st of work	ing	16b. I	Kind of Bus	iness/In	dustry	
12	vithin ne. han	mpi	Elementary/Secondary (0-12)	Coll	ege (1-4 <i>o</i> r 5	i+)		utive		,				Adv	erti	sing	
10 10	filed v Hygie ther t	ပိ	17. Father's Name (First, Middle,	Last)	-		DACC	CULIVE		18. Moth	er's Name	First, Middl	e, Maide				
an	id be ental ked o	To Be	Aaron								R	ose	Bloo:	m			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23e or 28e-f show any lary or other traumatic event, the Mcdical Examinar runal be routilise at ance.	-	19a. Informant's Name/Relations Elaine Clarke									ille,			State, Zip	Code)	
ē,	s 1 ar f Hea item other	1	20a. Method of Disposition			20b. Pl	ace of Dispo emetery, cre	osition (Nan	ne of	e)		Date	20c. l	ocation - C	City or To	wn, State	
E O	Page int: if		1 □ Burial 2 □ Cremation 1 □ Donation 5 □ Other (5		from State	1	orah (pr.5	,2006	Wes	t Pal	m Be	ach,	FL
Baltimore,	permit. Departm Importa any inju		21. Signature of Furieral Service	1200	1			254 Ca	irro1	ll St	., N	rchins W, Was	hing				Home
8760,	Continuous physician and patients as the burial-transit of for use as the burial-transit	icai Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a(b c	ue to (or as	a conseque	OS juence of):	5		ue l		or respirationy	allest,			Approxim Interval B Onset and	etween
.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	es, outcome Live birth Pregnant at Unknown	2 Fetal	death 3[⊒Ectopic pr ⊒ Other (sp						23d. Date Mon		ery Day	Year
٥.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant condit	ons contributin	g to death b	ut not resu	ulting in the t	underlying o	ause give	en in Part	l.			use contri 2 🖾 No			
Vital Records,	0 1 0	Completed										per	is an opsy formed?	pr	ere autorior to coeath?	inpletion of	s available cause of
ita	i cien : The certificate rector, pag	BeC	25. Was case referred to medica	1						26. Plac	e of Deat	h (Check only					
	S 50	To	examiner? 1 ☐ Yes 2 ☐ No	Hospital	1 🗌 Inpatie	ent 2 🗆 I	ER/Outpatie			- K 14		me 5 Re				y)	
n of	ng Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pendi		Date of Inju (Month, Da	y Year)	28b. Time of Injury		28c. Injury Work			28d. Describ	e how inj	ury occurre	id		
sio	Attending r death.	cati		gation not be	D1 (1-1			М		Yes 2	JNO	28f. Location	(Street	and Numba	r or Pur	I Pouto M	mher
Division	or All	ertification:	4 Homicide determ		Place of Inj building, et			reet, factor	у, опісе				own, Sta		i Di Mare	17 710016 140	anbor,
1	Hospital 4 hours a Funeral ety filled	dical Ce	29a. Certifier 1 Certifyi (Check only one)	ng Physician: Examiner: On	To the best the basis of d manner st	f examinat	wledge, dea ion and/or i	th occurred nvestigation	at the tim	ne, date a pinion, de	nd place, ath occur	and due to th	e cause(e, date a	s) and man	ner as s	tated.	e(s)
	To the within 2 To the complet	Med	29b. Signature and title of certific					290	c. License	e number			29d. D	ate signed	(Month,	Day, Year)	
)	F ≤ F ō		· Lul	H m	M	~	mr	2	00	05	061	2	a	pril	3	20	06
	^		30. Name and address of person	who complete	d cause of c	death (Item	23a) (Type	Print)									MG.
	2		SAMJEL	G. W	114	LE1	n	0,3	3305	N. I	eisu	re Wor	ld B	lvd.,	Sil	ver S	Spring,
	St Regist	ate rar	31. Date filed (Month, Day, Year	G. N 4 2006	32. Alegistr	rar's Signa	ture	bark	9								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31 Day 2006 ear **Physician** 10:30 A M HALPRIN Robert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 14412 Sandy Ridge Rd. If Under 1 Year Months Days 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Day, Dec . 25, Birthplace (State or Foreign Country) **Funeral** Months Hours 1935 70 Vrs Director 212-32-6556 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is markad othar than "natural", or itams 23a or 28a-1 show othar traumatic avant, the M-dical Exercites must be notified at 10d. Inside City Limits Silver Spring MD Montgomery 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 U.S.A. 14412 Sandy Ridge Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. OXYes 2 No WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ XNo Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Sales Salesman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental F Deborah Solomon Harry Halprin ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14412 Sandy Ridge Rd., Silver Spring, MD 20904 19a. Informant's Name/Relationship (Type, Print) Sandra Halprin / spouse Health Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: if ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State Judean Memorial Garden 04/03/06 Olney, MD ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral S mice Licensee 254 Carroll St., NW. Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a Acute Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner b. Coronary Artery Thrombosis Minutes Sequentially list conditions, a.y. cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requiras that the death certificate ba executed use as the burial-transit Coronary Artery Atherosclerosis Years physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical Hyperlipidemia Years IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Į, in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 TYes 2 □ No 3 Probably 4 □Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Nicotine Addiction performed? Yes 24 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Xatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the ! and manner stated 29b. Signature anartitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0009215 aurence April 3, 2006 LURCUS 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #207 Lawrence D. Marcus, MD 10313 Georgia Ave., Silver Spring, MD 20902 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Charle 2006 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 0510 **Johnson** APRIL Martin Anthony 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CUMBERLAND ALLEGANY MEMORIAL HOSPITAL

Months Days

10f. Zip Code

1 ☐ Yes 2 No

7. Age (In yrs. last birthday)

10c. City, Town or Location

Cumberland

43

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No ff Yes, Give Year or Dates:

1 M 2 F

If Under 1 Year | If Under 24 Hrs.

Hours

21502

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

8. Date of Birth (Month, Day, Year) May 29, 1962

М

9. Birthplace (State or Foreign

10d. fnside City Limits

1 ☐ Yes 2 ☐ No

Μ̈́D

10g. Citizen of What Country?

USA 14. Race - American Indian,

Black, White, etc.

CUMBERLAND, MD 21502

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Specify: white

Funeral Director

Physician

/Medical

Examiner

1 - For State Ragistrar

10a. State

Funeral Director

leted by

MD

11. Maritaf Status

5. Social Security Number

10e. Street and Number

218-88-7453

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

10b. County

Allegany

12610 Longs Hollow Road SE

Usual Residence of Decedent

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show "natural, or items 23s or 28s-f show adical Examiner must be notified at

Baltimore, Maryland 21215-0036

Priyai /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760.

	15. Decedent's (Specify only highest of	Education grade completed)	16a. Decedent's Usual Occu (Give kind of work done	pation during most of work	ding .	16b. Kind	of Business/li	ndustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	service manage	•		Auto	Supply	Со
lo be C	17. Father's Name (First, Middle, La Martin Johnso		1000	18. Mother's Nam	e (First, Middle, Johnsor	Maiden S	umame)	
-	19a. Informant's Name/Relationship Wilda Meyers	(Турө, Print) mother	19b. Mailing Address (Stree 12610 Longs	t and Number or Rui		r, City or	Town, State, Zi	D 21502
	20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Spe	☐Removal from State	Place of Disposition (Name of cemetery, crematory or other place) avis Memorial Cemeters of the place of the	ice)	Date 4/8/2006		ation - City or T nberland	
	21. Signature of Funeral Service Lic	1 Scarpe	108 Vir	ili Funeral Hoginia Avenue	e: Cumbei		MD 2150	
	23a. Part1. Enter the disease, or co shock, or heart faiture. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	NDARY TO STREPT		or respiratory a	rest,		Approximate Interval Between Onset and Death
uer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a const						
cal Evaluation	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conso	equence of):					
by Filysicial/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	ital death 3 Ectopic pregnanc			23	d. Date of define Month	very Day Year
-		s contributing to death but not re	esulting in the underlying cause g	ven in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
	Part II. Other significant conditions MULTIPLE ORGAN	FAILURE			10	res 2 🔀	No 3 Pro	babfy 4 Unkno
oundings and the		FAILURE			24a. Was		24b. Were aut prior to c death?	
combiered	MULTIPLE ORGAN 3			26. Place of Dea	24a. Was autor perfo 1 □ Yes	an osy rmed? 2, No	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availa ompfetion of cause of 2 No
na combience	MULTIPLE ORGAN	Hospital: 1 Sunpatient 2	□ ER/Outpatient 3□ DOA Ot	26. Place of Dea her: 4 ☐ Nursing Ho	24a. Was autor perfo 1 □ Yes	an osy rmed? 2, No	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availa ompfetion of cause (2 No
no pe combieren	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Naturaf 5 Pending investigal	Hospital: 1 V Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	her: 4 🗆 Nursing Ho	24a. Was autor perfo 1 □ Yes	an osy rmed? 2, No one dence 6	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availa ompfetion of cause of 2 No
to be completed	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 SUnpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	ther: 4 Nursing Hoursing Hours ork? Yes 2 No	24a. Was autor period 1 Yes th <i>Check only o</i> ome 5 Residue 28d. Describe I	an say rmed? 22 No one dence 6 now injury	24b. Were aut prior to c death? 1 Yes Other (Specoccurred	opsy findings availa ompfetion of cause of 2 No
Medical Certification: 10 be Completed by Pr	MULTIPLE ORGAN 25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Sunpatient 2 28a. Date of Injury (Month, Day Year) too t be 28e. Pface of Injury - At building, etc. (Spe	28b. Time of lnjury 28c. lnju Wo	her: 4 Nursing Hoursing Hours in American	24a. Wes autor performence of the check only come 5 Residue 28d. Describe I City or Tox	an systy sys	24b. Were authorito to death? 1 Yes Other (Special Control of the	opsy findings availa ompfetion of cause of 2 No No No No No No No No No No

DHMH 17 Rev 1/2001

State

Registrar

ROBUSTIANO BARRERA, M.D.

APR 1

7 2006

31. Date filed (Month, Day, Year)

500 MEMORIAL AVENUE

32. Rigistrar's Signature

			For State Registrar	State of Marylan		artment of F			ene 1,006	12008
П	Physicia	an	1. Decedent's Name (First, Middle,		40			2. Date of Death MARCH 29	Day, o C Year	3. Time of Death
	/Medic	al	CHRISTINE 4a. Facility Name (If not institution,	JENK II	V.S	4h City Town	or Location of Death		4c. County of Death	5:30 PM
	Examin	ęr	8104 DANIEL D			FOREST			PRINCE GE	
	Funeral	9		6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, y 4-16-55	9. Birth	nplace (State or Foreign
	Director		577-76-1310 Usual Residence of Decedent	50	Yrs.			4-16-55	ORAN	IGEBURG, SC
poole	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mo	88-f e	Director		E GEORGE'S	FOREST					1 X Yes 2 No
4	E Or 2	Dire	10e. Street and Number 8104 DANIEL D	RIUF		10f. Zip Code 207	147	-	J. Citizen of What Co. U.S.A.	untry?
doop	ms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. \		Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - Amer	
died within 70 hours after death with the Mandada	"natural", or Items 23c or 28e-f ehow	by Fui	1 XNever Married 2 ☐ Marrie	If Yes, Give		1 Tes, specify Cub 1 ☐ Yes 2 ② No	Specify:	Hican, etc.)	Black, White	
j j	itural.		3 Widowed 4 Divorced	Year or Dates:	16a, Deced	dent's Usual Occup	pation	16	BL ib. Kind of Business/l	_ACK
ה אוני	Market San Too	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done OO NOT use retire	during most of work	king		,
7	tal Hygiene. Id other than	Соп	12TH GRADE		RES11	DENT ADVI			DETENTION	CENTER
	e d ai	o Be	17. Father's Name (First, Middle, L WATSON JENRI				ELOUISI	e (First, Middle, Ma E SUMME		
ar yid	and Me	<u>۲</u>	19a. Informant's Name/Relationshi		19b. Mailin	ng Address (Street			City or Town, State, Z	ip Code)
, IM	475		VERONICA HARR	ELL-DAUGHTER		CROSS ST			MD 20747	
	or ot		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation	3 □Removal from State	emetery, cren	sition (Name of natory or other pla	C0)		c. Location - City or 1	
	perniii, Pages I an Department of Heal Important: If item 2 any injury or other once.	1	4 □ Donation 5 □ Other (Sp.21. Signature of Funeral Service L			MEMO. PAR Name and Addre			ANDOVER, M ANGLER FUN	
ם i	Deps impo any ir	- 10	Theodore	C. Timchne			ST., N. 1		DC 20002	
		Ä	23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the deat only one cause on each line.	Do not enti	er the mode of dyi	ng, such as cardiac	or respiratory arres	t.	Approximate Interval Between Onset and Death
	h sician /Medical	1 3	Immediate Cause (Final disease or condition resulting in death)	a. HYPERTENSI						Oliser and Death
	Examiner			Due to (or as a conseq	uence of):					
	184 	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. VIABETES Due to (or as a conseq	uence of):					
2000	and and -trans	Examiner	that initiated events resulting in death) Last	c. MORBID OBE. Due to (or as a conseq						
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00	inicate ig phys as the	ledic								
מַלַ	attending pt	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	Ideath 3	Ectopic pregnanc	y		23d. Date of deli-	very Day Year
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cords,	s been signed to should be detailed		PERIPHERAL_VA	SCULAR DISEASE				1 Tes	2√ No 3 Pro	obably 4 Unknown
בַּי	has be	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
		e Col	25. Was case referred to medical				GC Place of Door		vNo 1 ☐ Yes	2 No
	this cert al direct	To B	examiner?	Hospital:	ER/Outpatien	t 3 DOA	100000000000000000000000000000000000000		ce 6 Other (Spec	ify)
5 8	fler		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe how		
NISION A	death. ctor: After y the funer	ertification;	2 Accident investigation inves	ot be 280 Place of Injury At h	ome, farm, str		Yes 2 □No	28f. Location (Street	et and Number or Rui	ral Route Number.
	s after	Certif	4 Homicide determin	building, etc. (Specif	(y)	,,		City or Town,	State)	
200	To the nospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or an experience of the funeral or an experience or an experience of the funeral or an experience or an experien	edical (29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my know eminer: On the basis of examina and manner stated.	owledge, death	occurred at the tile vestigation, in my o	me, date and place, opinion, death occur	and due to the cau- red at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
i i	within To th comp	Me	29b. Signature and title of certifier	70)		29c. Licens	se number	29d	. Date signed (Month	, Day, Year)
	(50) a	MD		D0056	6184	3	-31-06	
7	(1)		30. Name and address of person w	M.D. 6400 MARLB	, ,		RICT HFIGH	HTS, MD 2	0747	
	Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's Signa				y mv 2	_ , ,	
	Registr	ar	APR 0 3 2	006 Been A	A) A	100				

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N.	8		1. Decedent's Name (First, Middle	Last)								2. Date of De	ath Da		Vana	3. Time	of Death
	Physici /Medi		Patsy Ann Je	nki	ns							APRIL			Year 1000	5:	30 AM
	Examir		4a. Facility Name (If not institution					4b. City	, Town, or	Location of	of Death		40	c. County			
		74	Western Maryland Ho	spit	al Center			Hage	rstown				Wa	shing	ton		
	Funeral		5. Social Security Number	6. Sex		je (In yrs.	last birthday)	If Unde	er 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	Ī	9. Birthp	lace (Stat	e or Foreign
	Director		218-30-8434	1 🗌	M 2 X]F	7	1 Yrs.	MOTITIS	Days	Hours	MIII),	Nov 7	19	34	Mary	zlanc	
	p _		Usual Residence of Decedent														
	hours after death with the Maryland turel', or items 23e or 28e-1 show al Exeminal must be notified at	_	10a. State 10b. County			10c. Cit	ty, Town or Lo	ocation							1		City Limits
	e-f-	cto	Maryland Was	ninc	ton		Hage	rsto	wn							1 <u>X</u> Y	es 2 No
	or 28	Director	10e. Street and Number					10f. Z	ip Code				10g. C	itizen of V	What Cour	try?	
	15 wi		1500 Penns	vlva	nia Aver	ue				21742				Ħ	S.A.		
	dea T	Funeral	11. Marital Status		2. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Dec				ecify Yes or No Rican, etc.)	o-	14. Race	e - Americ		,
9	or ite	T.	1 Never Married 2 Marn	ed	1 Yes 2 🕽						i, Fuerio	rican, etc.)	İ		k, White,		
03	all, a	þ	3 Nidowed 4 Divorced		If Yes, Give Year or Dates:			1 🗌 Yes	212 NO	Specify:				Specify	. Whi	.te	
2-0	d within 72 hours after death with the Marylan Jene. r then "nature!", or iteme 23e or 28e-1 show the Madical Extenirat must be notified at	Completed	15. Decedent (Specify only highes				16a. Dece			ation Juring mosi	t of work	2.0	16b. i	Kind of Bu	usiness/Inc	dustry	
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ā		To	Leon Charles	s Va	ughn					Em	ilv	Roxanna	a Zu	mbro			
Maryland 21215-0036	2 should be and Ment is marked		19a. Informant's Name/Relationsh	ip <i>(Typ</i>	e, Print)		19b. Maili	ng Addres	s (Street a			al Route Numb			State, Zip	Code)	21740
	5 # 7 # 1		Carolyn M. Buck	eho 4	t (daugh	+1	170	07 11	1100	1- 0		T-4 1	24 11				
ē,	S 1 a f Heg item othe		Carolyn M. Bucl 20a. Method of Disposition	4164	t turugi.	20b. F	Place of Dispo emetery, cre	sition (Na	ame of	110	ourt	ate 1	20c.	ager:	City or To	wn, state	yland
9	Pages 1 nent of He ant: if iten ary or oth		Burial 2 Cremation 4 Donation 5 Other (Sp	3 🗌 Re	moval from State		dar La					2006	На	gers	town	Mary	21742 Tand
Baltimore,	permit. Pag Department Important: if any injury o		21. Signature of Funeral Service I)	-	2:	2. Name a	nd Addres	s of Facilit	V Do						
Ba	Dep Imp		A Dunala -	NS	7							uglas A					
	g.	1	23a Part 1 Enter the disease or	complic	ations that cause	d the deat						N. Hag		.OWN	Mary.	Approxin	
		(23a. Part t. Enter the disease, or shock, or heart failure. List	only one	cause on each li	ne.			ac o. ay	g, 500. as	00.0.00	or respiratory a	11031,			Interval I	Between
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ш	J. 196	_	Sequentially list conditions,	b.	CONGE			27	PAIL	URE					- 1	1010 T	115
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90,	be executed sicien and burial-transit		3		Due to (or as	a conseq	querice or):										
8760,	ate hy:	dlcal		d.													
9	eath certific attending p	Mec	IF FEMALE:												-		
Вох	tend tend	an/	23b. Was decedent pregnant in the past 12 months?	23	c. If yes, outcome 1 ☐ Live birth]Ectopic _I	pregnancy						te of delive	_	Wass
-	the at	sicl	1 ☐ Yes 2 No		4☐ Pregnant a 9☐ Unknown	t time of c		Other (s						Mor	riuri	Day	Year
P.O.	tac by	Physiclan/Me	9 Unknown	1									l				
	8 6 8	þ	Part II. Other significant condition				sulting in the u	inderlying	cause give	n in Part I.	•	23e. Did 1	tobacco		ribute to th		
ıd	w requir been si should	ed	MYOCARDIAL	I	NFARCTI	ON						1 🗆	Yes 2	! [™] No	3 Prob	ably 4	Unknown
S	aw re	pet	CHRONIC UBS	TRU	CTIVE PI	ILMO	NARY	DISE	ASE			24a. Was		24b. \	Were auto	osy findin	gs available
Vital Records,	9 2 9	Completed											ormed?		orior to cor death? 		f cause of
ta		0	25. Was case referred to medical							26 Place	of Death	1 Yes	2200	3 1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2LJ NO	
		To B	examiner? 1 ☐ Yes 2 ☑ No	Н	spital:	ant 2	ER/Outpatier	nt 3 🗆 D	OA Othe			me 5 Resi		6 DOth	ar /Spacifi	d	
0			27. Manner of Death		28a. Date of Inju	IIV	28b. Time o		28c. Injury Work			28d. Describe				/	
0	nding I th. :: After e funer	atlo	1. Natural 5 ☐ Pending 2 ☐ Accident investig		(Month, Da	iy rear)	Injury	М		?? ∕es 2 🔲 l	No						
Division of	or Attending effer death. Director: Affer in by the fune	fice	3 Suicide 6 Could r		28e. Place of In	jury - At h	ome, farm, st	reet, facto	ry, office		-	28f. Location (Street a	nd Numb	er or Rura	Route N	umber,
ā	effer Dire	Certification:	4 Homicide		building, e	tc. (Speci	fy)					City or To	wn, Stat	θ)			
	To the Hospital or All within 24 hours effer or To the Funeral Directomplately filled in by		29a. Certifier 1 Certifyin	g Physi	cian: To the best	of my kno	owledge, deat	h occurre	d at the tim	e, date an	d place	and due to the	cause(s	s) and ma	nner as st	ated.	
	P Ho P Fu letely	Medical	(Check only 2 Medical I	xamin	er: On the basis of and manner st	it examina	ation and/or in	vestigatio	n, in my op	inion, dea	th occur	ed at the time,	date an	d place, a	and due to	the caus	Θ(S)
	To the within 2 To the comple	₩ W	29b. Signature and title of certifier					29	c. License	number			29d. Da	ate signer	d (Month,	Day, Year	·)
	->-0		> Mush	_ 1	1D				001	car				_			
			20 Name and address	2 '		doeth #:	- 000) (7			2,895			11/5	14	04,	1006	
SH	1-3		30. Name and address of personners PAMLINE DA	who con	npleted cause of c	oeath (Iter	п 23а) (Туре,			_							
ا		t o	31. Date filed (Month, Day, Year)		32. Begisti		ature		0	own, M	D 217	42					
	Sta Regist		APR 05	200	6 1	المالية	5. On	edi	•								

			1 - State Registrar	State of Marylar		ent of Health and ate of Death		ene 0 0 6	12010
	Physici	20	Decedent's Name (First, Middle,	Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medi		KAY HOS	DEN JOI	VES		03	28 2006	16:25 PM
	Examir	ner	4a. Facility Name (If not institution,		4b. C	ty, Town, or Location of Dea	ath	4c. County of Dea	
			PENINSULA REGIONA		ra	SAUSBURY		KICIMI	20
	Funeral Director		5. Social Security Number 222-01-8840 Usual Residence of Decedent	6. Sex 7. Age (In yrs.	3 Yrs. Month	der 1 Year ff Upder 24 Hr ns Days Hours Mir		9. Bin Co	thplace (State or Foreign buntry)
	within 72 hours after deeth with the Maryland ene. than "natural", or Itema 23e or 28e-f show he Madical Examiner must be notified at		10a. State 10b. County	10c. Cit	ty, Town or Location		-		10d. Inside City Limits
	Man fed	ţ	MA Som	ERSET	CHAN	OF			Tes 2 No
	r 284	Director	10e. Street and Number	- N3 E /	10f.	Zip Code	10	g. Citizen of What Co	puntry?
	h wit	<u>=</u>	ROLLING P	ARKE RAAD		21812		() <	24
	deet	Funeral	11. Maritaf Status	12. Was Decedent Ever in U		cedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ame	
9	after or ite	Ī	1 Never Married 2 Marrie	Armed Forces? 1 Tyes 2 No # Yes, Give		pecify Cuban, Mexican, Pue	erro Hican, etc.)	Black, Whit	e, etc.
5-0036	rai'.	1 by	3 Widowed 4 □ Divorced	Year or Dates:	1 1 10	2 No Specify:		Specify: 7	3 LACK
5-0	72 h natu	Completed	15. Decedent' (Specify only highest	s Education grade completed)	16a. Decedent's U	sual Occupation	ndking 1	6b. Kind of Business	Industry
21	within lene. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	1 1	work done during most of w Tuse retired)		_	^
2	filed w Hygier ther th	S	6		LABO	RER	ame (First, Middle, M.	SOBRYJON	ES OYSTERL
<u>n</u>	ild be fil sental H rked oth	Be	17. Father's Name (First, Middle, L				and the same of th	aiden Sumame)	,
yla	should nd Men marke umatic	္	MAJOR FRANC			SARA	4 DORSE	= 1	
Maryland	C/ C/		19a. Informant's Name/Relationsh		Mary and the second	ess (Street and Number or F		100	Zip Code)
-	1 and Health em 27 ither tr		GRACE POLLIVE	ER ~ DAUGHTER	7908-Du	WNHILLVILL			EMD 21244
Baltimore,	0 0		20a. Method of Disposition 1 Burial 2 □ Cremation		Place of Disposition (incometery, crematory)	Name of or other place)	Date 20	Oc. Location - City or	Town, State
E	Pa Pa		4 ☐Donation 5 ☐ Other (Sp	ecify) ST	CHARLESL	IM CH CEM :	4/3/06 (-HANCE	Mb.
a	Departr Departr Import any inju		21. Signatur of Feneral Service L	icensee	22. Name	and Address of Facility	SENNIE =	SMITH F/	4
ш_	80599		Muscel	In Kounes	917-1	W. I. SABELL	A ST. SF	LISBURG	MD21801
	Pnysician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List of firmediate Cause (Final disease or condition resulting in death)	complications that caused the deat nly one cause on each line. a. Due to (or as a consequence)	Prost	ode of dying, such as cardi	ac or respiratory arres		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a conseq	derice or).				
		ē	Sequentially fist conditions, if any, leading to immediate	b. Due to (or as a conseq	juence of):				
	be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ć,	n an	Exa	resulting in death) Last	C. Due to (or as a conseq	juence of):				
8760	ate be ex nysicien he burial	cai		d					
89	ificate g phys	edi		u.					
Вох	death certifica attending ph of for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of del	iverv
m	death e atte	Cia	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of d				Month	Day Year
P.0.	at the de by the a tached	hysi	9 Unknown	9□ Unknown					
т. С	or Attending Physicien: The law requires that the death certificate be executed bire death. Director: After this certificete hes been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director.	by P	Part II. Other significant condition	s contributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
r Sp	n sig	D D					1 ☐ Yes	2 🗖 № 3 🗆 Pr	obably 4 DUnknown
Vital Records,	w require been signature	Completed					24a. Was an	24h Were a	itopsy findings available
Be	The lav	Ĕ					autopsy performe	prior to death?	completion of cause of
Ø	ilcien: Th certificete ector, pag	ပိ	25. Was case referred to medical				1 □ Yes 2	⊒√No 1 ☐ Yes	2 No
5	s certific irector.	00	examiner?	Hospital: 1 Inpatient 2	IED/Outration and		eath Check only one		
ō	Phys r this aral di	2	27. Manner of Death	28a. Date of Injury	28b. Time of	DOA 4 Nursing	Home 5 Residen		cify)
o	ding P th. tunera	tlor	1 Natural 5 Pending 2 Accident Investiga	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		injury document	
Division	r Attsndi er death. rector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could no	ot be			28f. Location (Stre	et and Number or Ru	ral Boule Number
Ö	effer Offer Unit	erti	4 Homicide	building, etc. (Specil	ý)	ory, ones	City or Town,	State)	aar riodio reambor,
	To the Hospital or Attan within 24 hours effer deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyin (Check only 2 Medical E	Physician: To the best of my king xaminer: On the basis of examina and manner stated.	wladge death occur ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	e, and due to the oad curred at the time, dat	.55(5) and manner as e and place, and due	stateu. to the cause(s)
	ompf	Me	29b. Signature and title of gertifier			29c. License number	290	Date signed (Monta	h, Day, Year)
	(()		29b. Signature and title of definier					March 20	15 2001
	1 M/8			ho completed source of doubt the	220) /5 2	003/359		· Iwww as	, , , , , ,
	10		30. Name and address of person w	7FSAN III	n ∠3a) (Type, Print)	DO57359	ISBURY	MDYGU	
	Sta	10	31. Date filed (Month, Day, Year)	32. Registrar's Signa	2 · // : 0/3/	., -, 0	1-41-		
	Regist		MAR 3 1	2006					

DHMH 17 Rev 1/2001

320-01-8840

Jones

Please Type or Print in Black Indelible Ink

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of Maryland / Department of Health	and Mental Hygiene	1001
Certificate of Death	Reg. No. 2006	1201
t)	2. Date of Death	3. Time of Death

	hysician/
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<i>l</i> ledical	Examiner

Funeral Director

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Nedical Examiner must be notified at once.

Baltimore, MD 21215-0036 Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

_	Registrar								th			
	1. Decedent's Name (First, Mid	dle,Last)						Date of Dea Month		Voor		me of Death
er	Ernest	Omie	Johnson					April 9, 20	006 Day	Year	7	:35
ı	4a. Facility Name (if not institut				b. City, Town, or L	ocation of [Death			unty of Dea	ath	
	17452 Mount Zion C	hurch Road			St. Inignes				St. I	M a ry's		
٦	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	1	24Hrs. 8 Min.	B. Date of 8i	rth (MM/DD/		Birthplac Country)	
	220-66-8122	1 X M 2 F	49	Yrs.	Worth Days	Tiodis	IVIII I.	09/07	/1956			land
	Usual Residence of Decedent 10a. State 10b. County	,	10c City	Town or Location	on						10d	Inside City
					_						_	Yes 2
cto	Maryland St 10e. Street and Number	t. Mary's		1	St. In	ilgoes	3	- 11	0g. Citizen	of What Co	ountry?	
Ē		T 1	D 1									
<u> </u>	14822 Point 11. Marital Status		KOad Decedent Ever in U.S	S. 13. Was	ZU Decedent of Hisp)684 Panic Origin	? (Speci	fv Yes or No		ted S		
Funeral Director	1 Never Married 2 X	Married Armed	Forces?		es, specify Cuban,					White, etc.		·
<u>></u> ਜ	3 Widowed 4 D	ivorced If Yes, Give Y		1	Yes 2 X No	specify:			Spe	ecify: B	lack	ζ
Completed by	15. Decedent's Education (Sp			16a. Decedent	's Usual Occupatio	on (Give kin	d of work	done	16b. Kınd	of 8usiness	s/Indust	ry
lete	Elementary/Secondary (0-12	2) College	e (1-4 or 5+)		orking life. DO NO	T use retire	ed)					
ЩĆ	10				Laborer	0.14				Const	ruct	ion
	17. Father's Name (First, Middl				18				Maiden Sun	name)		
o Be	Omie Gladden 19a. Informant's Name/Relation			19h Mailiea	Address (Street			Johns		r Town Sta	ate 7 in 1	Code)
2			D 1 +		·						2065	3 '
	Ernestine M 20a. Method of Disposition	Jonnson /	Daughter 20b. P	ZZUZ4	Oxtord C tion (Name of cem	etery,	Apt	A6,	Lexí:	ngton ation - City o	Par or Town	K, MI , State
	1 X 8urial 2 Cremati	on 3 Remova	I from State C	rematory or oth-	er place)							
	4 Donation 5 Other		Mt.		lethodist					_	-	
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	Edward N. Brin	ngxield,	Jr. M000		955 Holly	wood	Road	l. Leo	nardt	own, l	MD 2	20650-
					a made of duina a	uch as agr	diag or ro	opiratory on	Toot shook			acavimata l
	failure. List only one caus		it caused the death.	Do not enter the	e mode of dying, s	uch as card	diac or re	spiratory an	est, shock,	or heart		proximate l etween Ons
	Immediate Cause (Firial diseas	se on each line. se a Ather o	osclerotic o	cardiovas	e mode of dying, s	such as card	diac or re	spiratory an	rest, shock,	or heart		proximate l etween Ons
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiener Hygien 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at core.		Funeral Dire	10e. Street and Number				10f. Zip Coo	de		10	g Citizen of What	Country?															
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe	After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live b	nant at time of deat	2 Fe	al death ner (S <i>pecify)</i>	3	Ectopic pregnal	ncy	23d Date of de Month	elivery Day Year															
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O.C.M.E.

April 6, 2006

State 31 Date filed (M Registrar

Carol Allan, MD

30 Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Pauline Virginia Kipe 31 2000 4c. County of Death 2:45A.M. /Medical MARCH 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Reeder's Nursing Home Boonsboro Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 23, 1905 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Yrs. 100 Director 214-09-4277 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location rel', or iteme 23a or 28a-f show Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 336 Devonshire Rd. 21740 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forcest 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 3℃Widowed 4 □ Divorced "naturel", White er than "nature, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ၉ Albert Orcutt Edith Smith. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : if item 27 is or other tra Robert L. Nearchos - Son Hagerstown, Mary land 2
Date 20c. Location - City or Town, State 12325 Richwood Drive 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ° 4 ☐Donation 5 Other (Specify) Ringgold Cemetery Apr. 3,2006 Ringgold, Maryland 21. Signature of Funeral Bervice License OSBOTME AFTER EFEITY Home, P.A. 425 S. Conococheague St. Williamsport, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or held failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Soven Dementie /Medical Due to (or as a consequence of): Examiner Dines 3 Algheriner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): death certificate be executed use as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Antenio Schoolie Completed 1 Yes 2 No 3 Probably 4 Horknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 3 NO To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be within 24 hours after de To the Funerel Directo completely filled in by the 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D (8019 MARCH 31, 2006 CM Ites-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4-1 DR. VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 301-739-7100 32. Pegistrar's Signature APR 03 State Registrar

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Baltimore, Maryland 21215-0036

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	iuts arter death with the marylan al', or items 23a or 28a-f show Exactinat fraust 5s notified at	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No-		American Indian, White, etc.
9	or it	by Fu	1 Never Married 2 Married	Yes 2 □ N If Yes, Give	° 1963–	1 ☐ Yes 2 ☐ No	Specify:	,	Specify:	White
Ś	72 nouts after death with the Maryland natural; or Items 23a or 28a-f show dical Examinant to notified at		3 Widowed 4 Divorced	Year or Dates:	1966	death Heral Con-	Non			
21212-0030	d within 72 hours giene. Prithan "natural;, the Medical Exa	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of work	ring	16b. Kind of Busin	ness/industry
7	within tene. than	Juo	Elementary/Secondary (0-12)	College (1-4or 5	+)	ck Drive			Moving/	Transport.
	E A E E	BeC	17. Father's Name (First, Middle, Last)		1 1 2 4				Maiden Sumame)	•
0	\$ \$ \$ \$	0	Clarence Kozm	inski			Florence	ce Cald	well	
Maryland	d 2 should th and Men 7 is marke treumatic		19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street a	nd Number or Rui	al Route Numbe	r, City or Town, Sta	ate, Zip Code)
	Health Health em 27 i		Linda Kozminsk	i/Wife		shmed Ct	., Elkt	on, MD	21921	
ב כ	2 - 2 0		20a. Method of Disposition 1 Strain 2 ☐ Cremation 3 ☐ F	Removal from State		matory or other place	Anri	Date 1 6,	20c. Location - Cit	ty or Town, State
	rag ment ant: I		4 Donation 5 Other (Specify)		Delawar	e Vetera	115		Bear, D	ÞΕ
pallillore,	permit. Page Department of Important: If eny injury or ODGE.		21. Signature of Funeral Service Licens	98	A	Y Name and Address	s of Facility	ineral	Home	
	40 = 0		23a. Part1, Enter the disease, or comp							21921 Approximate
			shock, or heart failure. List only o	lications that caused ne cause on each lin	the death. Do not en e.	ter the mode of dying	, such as cardiac	or respiratory are	est,	Approximate Interval Between Onset and Death
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. 450	vertion	Terminal	Aspirat	ion		30 min
	/Medical Examiner		resulting in death)	Due to (or as	consequence of):		-		,	
		<u> </u>	Sequentially list conditions,	b. Jun to lor as	consequence of):	ell (aveiron	a- L	ung	dyv
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	210 10 (31 40 1						
	be executed sicien and burial-transit	xai	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
00/0	cate be executed bhysicien and the burial-transit	dical	(d.						
0	g physicate as the	edi		Y						
YOU	i ne taw requires mai me deam centric ite has been signed by the attending p age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23d. Date of	of delivery
0	o all	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Other (specify)			Month	Day Year
ר. ס	at me de I by the stached	hy	9 Unknown					_1		
ກໍ	igned be det	by	Part II. Other significant conditions co	1	(3)	inderlying cause give	n in Part I.		,	ite to the cause of death?
Vilai necords,	been s	Completed	Squamous (e)	1 (avinou	na copy	ritorn s	inus	1.2Y	es 2 No 3	Probably 4 Unknown
ָט ט	hasb hasb	nple.						24a. Was a autop:	sy prio	re autopsy findings available in to completion of cause of
		S						perfor 1 Yes		th? Yes 2□ No
S :	certifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		Otho	26. Place of Deal			
ō i	this al dii	2	1 Yes 2 No	1 Inpatie			4 Nursing H		ence 6 Other ow injury occurred	
		tio.	1 Natural 5 ☐ Pending	(Month, Da)	Year) Injury	Work	es 2□No	200. Describe n	ow injury occurred	
2	of Attending of At	Certification;	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, st			28f. Location (S	treet and Number	or Rural Route Number,
5	effer Dire d in b	erti	4 Homicide	building, etc	. (Specify)	7,		City or Tow	n, State)	
	to the hospitel or Attanding within 24 hours efter death. To the Funeral Director; After completely filled in by the fune		(Check only 2 Medical Exami	ner: On the basis of	of my knowledge, deat examination and/or in	h occurred at the timi vestigation; in my op	e, date and place, inion, death occur	and due to the c	ause(s) and mann late and place, and	er as stated, if due to the cause(s)
	ithin 2 o the omplet	Medical	29b. Signature and title of certifier	and manner sta	ted.	29c, License			29d. Date signed (A	
	- 3 - 8			1 /						
			20 Nama and allace (/aco	W 110	Da!	1915		331	-Up
6	+ IVA		30. Name and address of person who c	Oripieted cause of de	anth (Item 23a) (Type,	- /// //	Nial	5+ 5	6214 5	1-06 115ton, NO
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	, W		J. JV11		,,,,,,,
	Regist		APR 0.4 2006	W. K	bracke					

DHMH 17 Rev 1/2001

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			1- For Amend#7 4/5/State of Maryland/L State Registrar Per FH. cmh AACO Healt	Jepa ₁ <i>Cer</i>	rtment of He tificate of D	eaith and N Death		giene Eeg. No.	006	12016	
			1. Decedent's Name (First, Middle, Last)	11			2. Date of Dea		Year	3. Time of Death	
	Physicia /Medic		Carol Marie I	Kerr	March			26	2006	4:00 p M	
	Examin	er	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death			
			208-C Victor Parkway 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rth day)	Annapo		9 Date of Birt		ne Arui		
	Funeral Director		093-30-0081 1□M 2X¥ 68 38	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Feb. 17	y, Year) 7, 19	38 Nev	hplace (State or Foreign wintry) WYork	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	m or Loc	ation					10d. Inside City Limits	
	death with the Maryland me 23a or 28a-f show friust be notified at	tor	MD Anne Arundel Anna	apo1	is					1 ☐ Yes 2XXXIo	
	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citiz	en of What Co	ountry?	
	23a c	aiD	208-C Victor Parkway		214	403			USA		
	teme	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	 Race - Ame Black, White 		
Maryland 21215-0036	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other then "naturel", or iteme 23a or 28a-1 show aumetic event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√√No If Yes, Give Year or Dates:	1	☐ Yes ※ XNo	Specify:			Specify:	White	
2	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	ent's Usual Occupa kind of work done di	uring most of work	ing	16b. Kin	d of Business/	Industry	
12	within bne. then	dmo	Elementary/Secondary (0-12) Coffege (1-4or 5+)	alto	00 NOT use retired)			Rea	1 Esta	te	
р О	Hygi Hygi other		17. Father's Name (First, Middle, Last)	arco		18. Mother's Nam	e (First, Middle,				
au	ould be Mental arked o	To Be	Eugene Hacker			Grace Mo	orris				
ary	shou and N and M		19a. Informant's Name/Relationship (Type, Print)	. Mailin	g Address (Street a	nd Number or Rur	al Route Numbe	er, City or	Town, State, 2	Zip Code)	
	and 2 palth a n 27 is				Tuliet La	ne, Arnol	Ld, MD 2	21012			
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State] 20b. Place of cemeter.	f Dispos	sition (Name of eatory or other place)	Date	20c. Loc	ation - City or	Town, State	
Ē	Pag tment tant:		4 □ Donation 5 □ Other (Specify) Metro		matory	,	_		imore,	MD	
Ball	permit. Pages 1 and 2 should be Department of Health and Menia Important: if tem 27 is marked eny injury or other traumetic es once.		21. Signature of Funeral Service Licensiae	22.	Name and Address Hardesty 12 Ridgle	s of Facility Funeral ev Avenue	Home, H	P.A. polis	, MD 2	1401	
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not ente						Approximate Interval Between	
4	Physician		Immediate Cause (Final disease or condition as Chronic obstructive palmonery disease or condition as Chronic obstructive								
	/Medical Examiner	35	resulting in death) Due to (or as a consequence	of):	/		1				
	2		Sequentially list conditions, b. Due to for as a Consequence	78%							
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	0.7.							
<u> </u>	execunand nand ial-tra	Exar	that initiated events resulting in death) Last Due to (or as a consequence	of):							
68760,	ificate be executed g physicien and as the burial-transit	edical	d								
	= O m		IS SEMALE.	-		· ·					
Вох	leeth certifi attending p i for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	1 3□	Ectopic pregnancy			2;	3d. Date of del Month	ivery Day Year	
o	The law requires that the deeth cert sie hes been signed by the attendin page 2 should be detached for use	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	5 🗆	Other (specify)				WOITH	Day 10ai	
ري ص	s that pred b	y P	Part II. Other significant conditions contributing to death but not resulting in	n the un	derlying cause give	n in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?	
g	w require been sig should b	led 1	hypertension hypor.	1. 1.1	demia		1)80	Yes 2□	No 3⊟Pr	obably 4 Unknown	
ecc	law re es be 2 sho	Completed by	,				24a. Was		24b. Were au	topsy findings available completion of cause of	
Œ	The law	Con						rmed? 2 No	death?	2□ No	
/ita	ician: Th certificete rector, peç	Be	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only o	ne)			
ot	Physician: r this certifice ral director, p	10	1	utpatient Time of		4 Li Hursing no	me 5 k escribe t			cify)	
o	Jing After	tion	1 Natural 5 Pending (Month, Day Year)	Injury	28c. Injury Work M 1 ☐ Y	es 2 □No	200. 9301100 1	iow injury	Occumen		
Division of Vital Records,	or Attending Physician: after death. Director: After this certifice in by the funeral director, i	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa	arm, stre					Number or Ru	ural Route Number,	
5	s after st Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)			Į.	City or Tov	vn, State)			
	To the Hospital or I within 24 hours after To the Funerel Directompletely filled in b	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and manner stated	e, death id/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)	
	To the Within To the comp	Me	29b. Signature and title of Carthier		29c. License	number		29d. Date	signed (Mont	h, Day, Year)	
			I CK "h KKmo		D	41816		3	3/28/	12006	
			30. Name and address of person who completed cause of death (frem 23a) have seen to be soon who completed cause of death (frem 23a) have seen to be soon who completed cause of death (frem 23a)	(Type, F	let Solin	mi Isla	nd Rd.	Anv	nepolis	MD 2140/	
	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	L	and the						

			1 = For State Registrar	State	of Marylar		artment of H		and M	_	giene Reg. No.	06	12017
			1. Decedent's Name (First, Middle							2. Date of De	ath _ Day	Year	3. Time of Death
	Physici /Medic		Joanne Louise l	Kryder						March	1 28, 2	2006	3:30 A M
	Examin		4a. Facility Name (If not institution				4b. City, Town, or	_	f Death			unty of Death	
			Casey House Mo				Rockvil					ntgomer	-
Ŀ	Funeral Director		5. Social Security Number 579-58-9029 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs.	last birthday) O Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da March	3, 194	9. Birthp Cour Wash	lace (State or Foreign http) ington, DC
	e filed within 72 hours after death with the Maryland of Hygiene. of Hygiene. of there then "nature!", or freme 23a or 28e-f e how yent. I'lle Medical Examine must be notified at	_	10a. State 10b. County Maryland Montgo	omerv	_	ty, Town or Lo						1	0d. Inside City Limits 1 ☐ Yes 2 🔼 No
	89-f	Funeral Director											
	with the	Ē	10e. Street and Number	uill Cima	1.		10f. Zip Code 20874					of What Cour	•
	e 23	era	20710 Crystal		zedent Ever in U	10 12			nin? (Co.	offu Van as Na		d State	
	iter de	ij.	11. Marital Status 1 ☐ Never Married 2 ☑ Marr	Armed F	orces? 2 (2)(No	1.3.	Was Decedent of Hi If Yes, specify Cuba	in, Mexican,	, Puerto	Rican, etc.))- 14.	Black, White,	
5	irs af	by F	3 Widowed 4 Divorced	If Yes G	ive		1☐ Yes 2⊠ No	Specify:			Spe	ecify: Whi	ite
3-UU36	2 hou	pe	15. Deceden	t's Education		16a. Dece	dent's Usual Occupa	ation			16b. Kind o	of Business/Inc	
2	in 7	pie	(Specify only highes Elementary/Secondary (0-12)) (1-4or 5+)	(Give	kind of work done o DO NOT use retired	during most I)	of workii	ng			·
7	d wit	Completed	12	-	(1-401-51)	Execu	tive Assi	stant			Count	try Clu	ıb
and	oth oth	4	17. Father's Name (First, Middle,	Last)	-					(First, Middle	, Maiden Sur	name)	
la l	Aente Aente rked tic e	To B	Joseph Briles					He1	en L	yons			
Mary nd 2 shoul	nd 2 sho eith and h 27 is ma	•	19a. Informant's Name/Relations Michael J. Krye				ng Address (Street a Abbey Mar						
altimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene. By injury or other treumatic event, the Maid cal Examine must be notified at Appa.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S)		State	cemetery, crei	sition (Name of natory or other places S Cemeter			ate 1 31,	20c. Locati Germa Mary 1	on - City or To .ntown, and	wn, State
	mit. porta y inju		21. Signature of Funeral Service	Licenso		22	. Name and Addres	s of Facility			neral I	Home, 1	.0 East
מ	88 5 8		MAn /	Mm	M0068	9 1	eer Park	Drive	e, G	aithers	burg,	Maryla	md 20877
			23a Part the disease, or shock or saft failure. List	complications that	caused the deal	Do not ent	er the mode of dyin	g, such as o	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Imm dia e Cause (Final diseas or condition				Obstruct:						Onset and Death
	/Medical		resulting in death)	a	(or as a consec								
	Examiner		Conventially list conditions	b									
-	D ==	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a consec	quanca of).							
	ate be executed hysicien and the burial-transit	Examiner	that initiated events	C									
5	e exe ien a ırial-i	Ĕ	resulting in death) Last	Due to	(or as a consec	quence of):							
00/2	ate b hysic he bi	ical		d									
ĕ	certificate be executed ading physicien and use as the burial-transit	Physician/Med	IF FEMALE:	T									
X O D	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 Peta	al death 3	Ectopic pregnancy				23d.	Date of delive	ory Day Year
_	e death the etter ned for u	sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Preg 9□Unki	nant at time of c	death 5	Other (specify)					World	Day Teal
	d by etach	P			t	h				20 - 514	1		
cords,	w requires thet the death certifical been signed by the ettending pland of the stending of should be detached for use as the second of the sec	by	Part II. Other significant condition	ons contributing to	seath but not res	sulting in the u	nderlying cause give	en in Part I.					ne cause of death? ably 4 Unknown
2	law rec es bee 2 shou	Completed								24a. Was	an 24	4b. Were auto	psy findings available
_	The lar	Ĕ									rmed?	death?	npletion of cause of
		ပိ	25. Was case referred to medical					OC Blace	of Dooth	1 Yes		1 🗆 Yes	2□ No
	Physician: rthis certific ral director,	0 8	examiner? 1 ☐ Yes 2 🛣 No	Hospital-	Inpatient 2	ER/Outpatier	othe Othe			Check only	_	Other (Sees)	Hospice
0	E E -	1	27. Manner of Death		of Injury ofth, Day Year)	28b. Time o				28d. Describe			// 110 SP 1 0 0
DIVISION	th. After	ē.	1 Accident 5 Pendin 2 Accident investig	9	nth, Day Year)	Injury		k? Yes 2∐N	No				
S	Attended of the by the	ifica	3 ☐ Suicide 6 ☐ Could	ined 289. Plac	e of Injury - At h	ome, farm, str	eet, factory, office			28f. Location (Street and Ni	umber or Rura	l Route Number,
5	spital or Attending Physours efter death. serel Director: After this filled in by the funeral dir	Certification;	4 Homicide	build	ling, etc. (Specia	fy)				City or To	wn, State)		
	To the Hospital or Attending Pl within 24 hours etter death. To the Funerel Director: After t completely filled in by the funera	edical C	29a. Certifier 1⊠ Certifyir (Check only one) 1 Medical	Examiner: On the	e best of my kno basis of examina nner stated.	owledge, deat ation and/or in	n occurred at the tim vestigation, in my op	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as si ce, and due to	lated. o the cause(s)
	o the	Me	29b. Signature and title of certifie				29c. License	number			29d. Date si	gned (Month,	Day, Year)
	-s+ō)	\sim	^		D356	35			March	28, 20	006
			30. Name and address of pers	who completed as:	ise of death fito-	m 23a) /Tuna	Print)						
حني	12		Joseph Kaplan,	M.D. 600	1 Munca	ster M	111 Road,	Rock	vill	e, MD 2	20855		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0	4 2006	Registrar's Signa	di A	parte						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar AMEND # 20b, cperFH4/6/06, BMW, MC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day HELEN YEN KOO MARCH 26, 2006 8:24 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL BETHESDA MONTGOMERY 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 ☐ M 2 🕅 F Yrs. 577-46-3845 80 MAY 8, CHÍNA Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No MD. MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5310 DANBURY RD. 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2X No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced ASIAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ SCIENTIFIC RESEARCHER F.D.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WEN KUEI YAN ZHI OING WANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD YAN/NEPHEW 5310 DANBURY RD., BETHESDA, MD. 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ROCKVILLE, MD 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKLAWN CEMETERY 4-8-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY ARTERY DISEASE Due to (or as a consequence of): COMPLETE HEART BLOCK Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): ome of pregnancy th 2 Petal death 23d. Date of delivery 3 Ectopic pregnancy Day int at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1☐ Yes 2♥ No

Physician /Medical **Examiner** neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

Funeral

Director

28a-f

or other traumatic event, the Madical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth with to Depertment of Health and Mentat Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 2 any injury or other traumatic event, the Medical Examinar must be nonce.

Baltimore, Maryland 21215-0036

the Maryland

Examiner Physiclan/Medical ģ Be Completed Certification: To

FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outc 1 ☐ Live bir 4 ☐ Pregna 9 ☐ Unknow
9 DONKHOWN	

Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part

25. Was case referred to medical				26. Place of Deat
examiner? 1 ☐ Yes 2X No	Hospital:	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Ho

ace of Death (Check only one)								
Nursing H	ome	5 Residence	6 ☐Other (Specify)					
	294	Describe how in	unt convered					

I Hes ZX	140	1 X Inpatient
7. Manner of Deat	h	28a. Date of Injury (Month, Day Yea
1 🗖 Natural	5 Pending	(Month, Day Yea
2 Accident	investigation	Z.
3 Suicide	6 ☐ Could not be	28e. Place of Injury -
	determined	200. I lave of littling

28b. Time of Injury	28c. Injury at Work?	
М	1 🗌 Yes	2

М	28c. Injury at Work? 1 Yes	2 □No	28d.	Describe	how	injury	occurr
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Could not be determined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Certifying Physi Medical Examin	cien: To the best of my knowledge, death occurre	d at the time, date and place, and in my opinion, death occurr	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)

	(Check only one)	2 🗆 1	Medical Ex		On the basis manners	
29b.	Signature an	nd wife o	of certifier	//	1	
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29c. License number 29d. Date signed (Month, Day, Year)

D-30885

30.	Name	and	address	ď	per	n/en	cor
			4444	~	Put		

29a. Certifier

impleted cause of death (Item 23a) (Type, Print)

RIKES

20816 5530 WISCONSIN AVE. SUITE 511, CHEVY CHASE, MD.

State Registrar

Medical

THOMAS S. GOLDBAUM, M.D. 31. Date filed (Month, Pay, Year) 32 Registrar's Signature

1 Certifying Phy

death.

within 24 hours e

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registreamend #27 per phy g854 4/17/Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day William Month Year **Physician** 03:50 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Shock Baltimore Baltimore Inauma If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Yrs. Director 65 389-38-3344 08/03/1940 MINNESOTA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23s or 28s-f show the Medical Exeminar must be notified at 1 Yes 3 No EARLEVILLE MD CECIL Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21919 31 MAYHEW AVE. USA filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: Specify: WHITE þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry it of Health and Mental Hygiene.
If Item 27 is marked other then or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 99 Pages 1 and 2 should by thent of Health and Ments tent: If Item 27 is marked William Maynard Lowrey Irene Nellie Buck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Short/Fiance 31 MAYHEW AVE. EARLEVILLE, MD 21919 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
CHESAPEAKE 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or once. CREMATION CENTER 13/27/2006 CHESTER, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 226 E. Main St. Cecilton, MD 21913 a. Juni. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Johnock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intra Parenchymal Due to (or as a consequence of): bleeding /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an this certificate has page 2 autopsy 1 ☐ Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 2 PER/Outpatient 3□ DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred onding investigation 1XXVatural death М 1 ☐ Yes 2 ☐ No Il Director: / 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 17062 06 2 (12)1961 30. Name and completed cause of death (Item 23a) (Type, Print) Grene St, Balfinare La 31. Date filed (Month, Day, Year) 32. Registras Signature State APR 03 Registrar

DHMH 17 Rev 1/200

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 18 per fh 9854 4-17-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Bettv Jane McKay April 12 .2006 10:40A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Apr 21, 1926 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 M 2 KF 215-20-6856 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.

and: If team 27 is marked other than "natural", or Items 23s or 28s-1 show my or other traumatic event, "a Medical Examinant mail to profitted at MD Allegany Cumberland 1 Yes 2 No by Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13400 Beall's Mill Road 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Booking Dept. 18. Mae's Bed (Fet, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be -Maebell (Wilson) True J.W. True 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13400 Beall's Mill Road Cumberland MD 2 19a. Informant's Name/Relationship (Type, Print) MD 21502 Cyril McKay Jr. husband 20a. Method of Disposition
1 ☐ Burial 2 ☐ Oremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Depertment of H Important: If ite eny injury or ot once. Scarpelli Funeral Home, P.A. 4/13/2006 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death tmmediate Cause (Final LEFT ISCHEMIC CEREBROVASCULAR ACCIDENT Frysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ng physiclen and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ATRIAL FIBRILLATION, TYPE II DIABETES MELLITUS 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ctor: After this 28a. Date of tnjury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signatu title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO ddress of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DR.STEVEN

31. Date filed (Month, Day, Year)

SMITH

7 2006

32. Registrar's Signature

900 SETON DRIVE CUMBERLAND, MARYLAND 21502

			1 - For State Registrar	State o	f Marylan		artmen rtificat				lental Hyg	iene g. No. () (16	12021
			1. Decedent's Name (First, Middle, Las	st)							2. Date of Deat Month	h Day	Year	3. Time of Death
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	Examin		4a. Facility Name (If not institution, give	e street and nur	mber)		4b. City,	Town, or	Location of	of Death		4c. Count	y of Death	
			CHERRY LANE NURS	ING HOM	Ε			AURE				PRIN	CE GE	ORGE 'S
	Funeral		5. Social Security Number 6. S	ex □M 2⊠F	7. Age (In yrs. I		If Under Months	1 Year Days	If Under	Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
	Director	APPRILE 21 1926 NORTH APPRILE 21 1926		ΓΉ CAROLINA										
	pu s				10c Cin	v Town or Lo	cation							10d. Inside City Limits
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Baltimore,	rtmer rtant njury								-					
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o.	the d	yslc				54.11	_ O(1101 (3)			****				
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Division	i Dia	erti	4 Homicide determined	build	ing, etc. (Specif	y)	1000, 10000	y, omos					00, 01, 12,	
	pita ours berei		29a. Certifier 1X Certifying Pt	nysician: To the	e best of my kno	wledge, deat	h occurred	at the tin	ne, date an	nd place	and due to the co	ause(s) and m	anner as s	stated.
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2.			APR 0 3 2006	Klas	1	A. Carrie								

			State of Ma					Mental Hy	giene	700	10000
			Registrar 1. Decedent's Name (First, Middle, Last)		Sertific	cate of	Death	2. Date of D	Reg. No.	JUO	12022
1	Physici	an	Margaret M. McC					Month O	Day	2006	3. Time of Death 0950 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	organ		City, Town, or	r Location of De		-	County of Death	0 100
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) es	Funeral Director	(US)	5. Social Security Number 6. Sex 7. Age 1	(In yrs. last birthe 98 Yr	Mor	nder 1 Year oths Days	Hours Mi		I 908	9. Birth Cou New	
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location						10d. Inside City Limits
	ath with the Marylan s 23a or 28e-f show	tor	MD Worcester	Ber	lin						1 ☐ Yes 2X No
	ith the Ma or 28e-f	Director	10e. Street and Number		10	f. Zip Code			10g. Citize	en of What Cou	intry?
	ath wi		1 Moonraker Rd.			21811			USA		
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other then "netural", or Items 23a or 28e-f show umatic event, the Modical Exeminal must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3XWidowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2XN If Yes, Give Year or Dates:		If Yes	es X No	lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or Nerto Rican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.
5-0	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. C	Decedent's	Usual Occup	nation during most of w	rorkina	16b. Kind	d of Business/Ir	ndustry
121	within sne. t hen	mpi	Elementary/Secondary (0-12) College (1-4or 5-	+)	pervi		i)	y	Tolo	phone C	ompany
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lor	Pages nent of H int: If ite		1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Cometery,						ation - City or T	
ij	nit. P artme ortani Injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Johnson	Long 1			Cem 4-	/-2006 he Burba		Island	
Ã	permit. Departr Import		1. But Dulage					Berlin,			ome
	**************************************		23a. Part1. Enter the disease, or complication, that caused shock, or heart failure. List only one cause on each lin.	the death. Do no	ot enter the	mode of dyin	ng, such as card	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Pneu	umonia	υ						Onset and Death
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+ 05	Physicien: rthis certific ral director, i	၉	1 Yes 2 No Hospital: 1 Inpatier			DOA Oth	4 🗀 140121116	Home 5 ☐ Res	sidence 6	□Other (Speci	fy)
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	To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/	death occi or investig	irred at the tir ation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time	e cause(s) a o, date and p	nd manner as s place, and due i	stated. to the cause(s)
	To the To the Company	Σ	29b. Signature and title of certifier	(14	<i>-</i> ,	29c. Licens	e number	/2	29d Date	signed (Month,	Day, Year)
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			For State Registrar	State of Mai	•	artment of F		nd Mental Hy	giene Reg. No.	006	12023
2	Physici /Medic		1. Decedent's Name (First, Middle, La John D. Mana					2. Date of De Month	Day 3	2006	3. Time of Death A 0553 M
	Examin	- 1	4a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, o				County of Death	
- 10 mg		vii.	Washington Count				gersto			Washing	
	Funeral Director		219-66-0330	Sex 7. Age 1 ☑ M 2 ☐ F	(In yrs. last birthday, 54 Yrs.	Months Days		Min. 8. Date of Bir (Month, Date of Bir Sep 2,	1951	9. Bilth Cou	place (State or Foreign ntry) PA
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
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	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?
	23a c	rai	13736 Wolfsvil				21783			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: if Item 27 is marked other than "naturel', or Iteme 23a or 28e-f ehow any Injury or other traumatic event, I'm Medical Examinal must be notified at once.	by Funeral Director	11. Marital Status 1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ★ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origir an, Mexican, F Specity:	n? (Specify Yes or No Puerto Rican, etc.)		4. Race - Ameri Black, White Specify: W	
21215-0036	in 72 hou n "nature dealicel E	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	(Give	edent's Usual Occup e kind of work done DO NOT use retired	nation during most o	of working	16b. Kin	d of Business/li	ndustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+		er worked	1		nev	er work	ed
멀	e file al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Las					Name (First, Middle		Gumame)	
yla	Ment Ment arkec	To	Marshall B. Ma					elyn E. Ko			
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship Nancy Burns	(Турө, Print) sister				or Rural Route Numb Aynesboro,			p C000)
	1 and Healt Healt Sther		20a. Method of Disposition	313001		osition (Name of omatory or other place	x	Date	_	ation - City or T	own, State
ΘĽ	ages ant of at: # II		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Elias Lut			04/06/06	Emmi	tsburg,	MD
Baltimore,	permit. F Departm Importar eny Injui		21. Signature of Funeral Service Lice		2	2. Name and Addre	ss of Facility	Grove-Bowe . Waynesb	ersox	Funera	1 Home, Inc.
			23a. Part1. Inter the disease, or conshock, or heart failure. List only		he death. Do not er	nter the mode of dyir	ng, such as ca	ardiac or respiratory a	arrest,		Approximate Interval Between
3	Physician /Medical Examiner	her	Immediate Cause (Final disease or condition resulting in death) Saque tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Neso, Due to (or as a	consequence of):	tailur	e			-	Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. De to (or as a	consequence of):	ale_					
O. Box	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc: □ Other (specify)	у		2:	3d. Date of deli Month	very Day Year
rds, P.	quires that n signed t	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.				the cause of death?
Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed					···		opsy formed?	24b. Were autoprior to death?	topsy findings available ompletion of cause of
ita	icien: certifica rector, j	Be	25. Was case referred to medical examiner?					of Death (Check only	on <i>e)</i>		
of \	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No	Hospital:		HIL 3 DOA		sing Home 5 Res			ufy)
Division (ding T. After fune	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not		Year) 28b. Time Injury	Wo	ryat rk?]Yes 2 □ Ne				
DIX	itel or Attenders after deatled Director:	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ry - At home, farm, s . <i>(Specify)</i>	treet, factory, office			(Street and own, State)		ral Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medicai	(Check only 2 Medical Exone)	Physician: To the best of aminer: On the basis of and manner state	examination and/or i	nvestigation, in my	opinion, death		, date and	place, and due	to the cause(s)
	To the within 2 To the complete	2	29b. Signature and title of ceriffer)	- Da	0619	90	29d. Date	3/04	2/783
X	4-7		30. Name and address of person with	o completed cause of de	ath (Item 23a) (Type	Print)	00.	a hom.	that	, h 1	21583
	6	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Thorne	11 /3/14	DISC.	MUNIC	in Ind	1 103
	Regist		APR 05	2006 Jane	w 1. 1	perke					
DH	IMH 17 Rev 1/2	2001			1						

ORIGINAL

			For State Registrar	State o	f Maryland		rtment of H tificate of L		Mental Hy	/giene	06	g - Palain registration	202	14
			1. Decedent's Name (First, Middle,	Last)					2. Date of D Month	eath Day	Ye		3. Time of I	Death
	Physicia /Medic		ANNA	L MIL					April		2000		1:07	_A M
	Examin	_	4a. Facility Name (If not institution,				4b. City, Town, or		th		County of [
No. of the			Frederick Memor		7. Age (In yrs. la	ast hirthday)	Frederi If Under 1 Year		s. 8. Date of B	irth	Frede:	Birthpla	ce (State or	r Foreign
	Funeral Director		236 -46-1557	1 □ M 2 🙀 F	75	Yrs.	Months Days	Hours Min	OCT 1		930 1	Country JEST	VIRG	TNTA
à	TO		Usual Residence of Decedent		10.00	-				,			d. Inside Cit	
	arylar ehow	7	10a. State 10b. County		10c. City,	, Town or Loc						100	1 Tyes	
	he M	Directo	MARYLAND WASH	IINGTON			LNOX 10f, Zip Code	VILLE		10g. Citi	zen of Wha	t Countr	v?	
	with t	급	2434 KAETZEL ROA	JD.				1758			U.S.		,	
	ne 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.S	S. 13. V	Vas Decedent of H Yes, specify Cuba		Specify Yes or N	10-	14. Race -	Americar		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Itame 23a or 28a-f show any njury or other traumatic event, It a Madical Examination and Differ maintified at another.	by Fur	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed For ad 1 ☐ Yes If Yes, Gir Year or D	2⊠No ve		Yes, specify Cuba	Specify:	no Alcan, etc.)		Specify:	White, et	c. WHTTE	3
Ŏ	r2 hou		15. Decedent' (Specify only highest	s Education			ent's Usual Occup		orking	16b. Ki	ind of Busin			
215	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. E	OO NOT use retired	1)	•					
7	led w tygien her th		17. Father's Name (First, Middle, L	acti			BEAUTIC		ame (First, Midd		NURSII	NG H)ME	
	t be fi	Be.	LEONARD LEE REY						MATILDA					
<u> </u>	should ind Men ind marke imarke	5	19a. Informant's Name/Relationsh			19b. Mailin	g Address (Street					ite, Zip C	iode)	
<u>≅</u>	nd 2 sulth ar		PAUL K. MILLS/S			2434	KAETZEL	ROAD, KI	NOXVILLE	E, MAI	RYLANI	D 2.	1758	
re,	s 1 ar f Hea Item otha		20a. Method of Disposition		Ce	lace of Disposemetery, cren	sition (Name of natory or other place	e)	Date	20c. Lo	cation - Cit	y or Tow	n, State	
Ë	Pages nent of h ant: If Ite ury or o	1	1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp		State	•	G CREMAT	1	/05/06	SMI	THSBL	RG.	MARYI	LAND
Baltimore,	permit. Departm Imports any nju		21. Signature of Puneral Service	cen e	ulM. Dea	22	Name and Addre	ss of Facility	7606 0	ld Na	ationa	1Pil	кe	
<u> </u>	89 E 2 9		Taul M	1120					Boonsb		Mary1		2171	
te/			23a. Part1. Enter the disease, or shock, or heart failure. List of	only one cause on	caused the death each line.	n. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory	arrest,		1	Approximate Interval Betv Onset and D	ween
l la	Physician		Immediate Cause (Final disease or condition resulting in death)		Stroke									
	/Medical Examiner		resulting in death)	Due to	(or as a consequ									
		ē	Sequentially list conditions, if any, leading to immediate	b. Dire to	(or as a consecu		sease					-		
160	uted d	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
ó	exectan an an arial-tra	Exa	resulting in death) Last	Due to	(or as a consequ	uence of):								
8760,	cate be executed physician and the burial-transit	Ical		d.								-		
9	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medl	IF FEMALE:											· fr
Вох	attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2☐Fetal nant at time of de	Ideath 3	Ectopic pregnancy	/			23d. Date of Month		-	Year
0		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkr		eatri 5	Other (specify) _							
<u>α</u>	requires that the de leen signed by the a hould be detached t	y Ph	Part II. Other significant condition	ns contributing to c	death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Die	d tobacco u	use contribu	ute to the	cause of d	death?
rds	quires n sign uld be	d by							1 [Yes 2	□ No 31	☐ Proba	bly 4 dl	Únknown
of Vital Records,	s been si	Completed							24a. W	as an lopsy	24b. We	re autop	sy lindings	available
æ	The law	шо							pe 1 Tyes	rformed2	dea	th? Yes 2		
ita		BeC	25. Was case referred to medical examiner?						eath (Check onl	v one)				
Ž <	S S	To	1 Yes 2 No			ER/Outpatier		4 LI Nulsing	Home 5 Re					
D U		on:	27. Manner of Death 1. Natural 5 Pendin	9	of Injury oth, Day Year)	28b. Time of Injury	Wor	yat rk? Yes 2 ∐ No	28d. Describ	e now injui	ry occurred	l		
isio	Attending F r death. ector: After by the funer	cat	2 Accident investig	201 50	e of Injuny - At ho	ome larm etr		195 2 140	28f. Location	(Street an	nd Number	or Rural	Route Nurr	nber,
Division	P die	ertification:	4 Homicide determ	build	ding, etc. (Specif)	y)	eet, factory, office			Town, State				
	Hos Fun Fely	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To th Examiner: On the l	ne best of my kno basis of examina nner stated.	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time	ne cause(s e, date and) and mann d place, an	ner as sta d due to	ited. the cause(s	s)
	To the Hos within 24 ho To the Fun completely	Med	29b. Signature and title of certifie				29c. Licens	se number		29d. Da	ate signed (Month, E	ay, Year)	
	- S - 0		12.	1 (In day	_	D894	45590		Д	PRIL	2, 2	.006	
			30. Name and address of person	who completed call	use of death (Item	n 23a) (Type,						_, _		
31	1-7		R.L. Jacobs,				T SEVENTE	I STREET	, FREDE	RICK,	MD	2170	1	
一家では	St Regist	ate rar	31. Date filed (Month, Day, Year)	5 2006	Registrar's Signa		rester							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death		ene 0 0 6	12025
	Physici		Decedent's Name (First, Middle, Last) Rebecca May Moses		2. Date of Death Month March 31	, 2006 Year	3. Time of Death 11:06 PM
			4a. Facility Name (If not institution, give street and number) Homewood Retirement Center	4b. City, Town, or Location of Death Williamsport			
 Zai	Funeral Director		229-36-9483 1 N 2 F 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 1)	9. Bin 1927 V I I	thplace (State or Foreign puntry) rginia
The content of the							
215-0036	thin 72 hours after de. e. an "natural", or Item Medical Examinet.	A Donation Donatio		ite			
and 21;	Security area of non-invalidation gree street and number Security flowers Security		artment				
more, Maryl	Pages 1 and 2 shouk ient of Health and Me nt: If Item 27 is mark ry or other traumati	-	19a. Informant's Name/Relationship (Type, Print) Paula L. Moses (Daughter) 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State	ing Address (Street and Number or Rui Intillary Way Mart osition (Name of imatory or other place)	insburg, Date 20	West Virg	inia, 25401 Town, State
Balti	permit. Departm Importa any Inju		21. signature - uneral Service Licensee	2. Name and Address of Facility Sborne Funeral Hor	me P.A. 4	25 South (
	/Medical Examiner	cai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events BRATIV TYMO Due to (or as a consequence of): C.	MENTIA	or respiratory arres	τ,	Approximate interval Between Onset and Death SEVERAL YEAR DYEARS
Box 6	he death certifica / the attending ph ched for use as th	ysician/Med	23b. Was decedent pregnant in the past 12 gnonths? 1☐ Live birth 2 ☐ Fetal death 3				
<u>α</u>	equires that t en signed by ould be detai	þ		underlying cause given in Part I.		1	
al Reco	n: The law r licate has be r. page 2 sh				autopsy performe 1 Yes 2	prior to death?	completion of cause of
ion of Vit	nding Physicial th. : After this certif	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury	ont 3 DOA Other: 4 Nursing Hor	ome 5 Residen		cify)
Division	itel or Atter irs after dea rel Director led in by the	Certifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		City or Town,	State)	
	the Hosp thin 24 hou the Fune mpletely til		one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	rvestigation, in my opinion, death occur	red at the time, dat	e and place, and due	o to the cause(s)
)	£ ₹ ₹ 8		30. Name and address of person who completed cause of death (Item 23a) (Type	D0047234	250	11106	, , , , , , , , , , , , , , , , , , , ,
31	Sta Registr			SYLVANIA AVE	HAGERS	STOWN /	MD 21142

			1 - For State Registrar	State of	of Marylar		artment of rtificate o			_	giene Reg. No.	00	6 1	20	26
	Physici		Decedent's Name (First, Middle Anna Marie	e, Last) Meades						2. Date of De Month March	Day	2006	ear	3. Time of 2:15	Death a M
Support.	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town	, or Location	of Death	naron	1	ounty of I		2.13	
			Holy Cross Ho 5. Social Security Number	ospital 6.Sex	7. Age (In yrs.	last hirthday		r Spri		8. Date of Birt			omery		- F
	Funeral Director		187-12-6727	1 □ M 24□ F	83	Yrs.	Months Day		Min.	(Month, Da	y, Year)		. Birthplace <i>Country)</i> Penns)	
	ס		Usual Residence of Decedent		3411,										
	faryla show	ក				ity, Town or Lo							10d.	Inside Cit	
	28a-	Director	Maryland Monto	gomery	Sı	lver S	pring 10f. Zip Code	1			10g. Citize	on of Wha	at Country		
	death with the Maryland me 23s or 28s-f show frount be natified at		2100 Washing	ton Avenu	e, #2D		209					USA	,		
	r deal	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in U	J.S. 13.	Was Decedent of	Hispanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)	- 14		American White, etc.		
30	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes G	2 No ive		1□Yes 2⊠N					pecity W		•	
2-003	2 hou		15. Deceden	t's Education		16a. Dece	dent's Usual Occ	upation			16b. Kind	of Busin	ness/Indus	try	
7	ithin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College ((1-4or 5+)	life.	kind of work don DO NOT use reti	red)		ng					
7	iled w tygier ther th		17. Father's Name (First, Middle,	(201)		Intel	lligence			(Fire Added)			Gove	rnmer	nt
and	d be f ental h ked of c ava	To Be	Herbert Brown	Lasi)						<i>(First, Middle,</i> a Aull	маюел 5	ımame)			
ary	should Mand Mand	۲	19a. Informant's Name/Relations			19b. Mailii	ng Address (Stre	et and Numbe	er or Rura	l Route Numbe	r, City or 1	Γο w π, Sta	ite, Zip Co	de)	
E,	and 2 ealth a m 27 I	ij	Stuart Lempert	:/Executo:		_		Line	Road	, Silve	r Spr	ing,	MD :	20906	5
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Important: If the Z1 is marked other than "natural; or freme Z3a or 28a-f show any injury or other traumatic avant, the Mudical Examinar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	cemetery, crei	osition (Name of matory or other p		March	n 31,	20c. Loca	ition - Cit	y or Town,	, State	
altimor	artmer entmer enjury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service	·	Gat		aven Cemet	ery	2	006				, Mar	ylan
0	Depermine Depermine Important Important Important Important Irrangement Important Irrangement Irrangem) James	3000	24	50	allers of Onive	rsity	Rlvd	w, Si	lver	Spri	ng,	MD 20	901
	161		23a. Part1. Envir the disease, or shock, or leart failure. List	complications that	caused the dea	th. Do not ent	ter the mode of d	ying, such as	cardiac o	r respiratory ar	rest,		Int	proximate terval Betv	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	Asyst	tole								Or	nset and D	eath
	/Medical Examiner		resulting in death)		(or as a consec										
		Jer	Sequentially list conditions, in a leading to in hedday cause. Enter Underlying		ial Fibi		Lon						-	··········	
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
000	icate be executed physician and s the burial-transit	ai E	rossing in osain, case	Due to	(or as a consec	quence of):									
0	ificate g phys	edicai		d					.,						
5	th cert tendin r use	an/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		⊒Ectopic pregnan	icv			236	d. Date of			
5	w requires that the death certifice been signed by the attending is should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregi 9□Unkn	nant at time of o		Other (specify)					Month	Da	y Y	'ear
	that the hold by a detact		Part II. Other significant condition	ons contributing to d	leath but not res	sulting in the u	nderlying cause g	jiven in Part I.	l,	23e. Did to	bacco use	contribu	te to the c	ause of de	eath?
25	en sig	ed by								1 🗆 Y	'es 2 □ I	No 3[Probably	y ¥≹u	nknown
ט ט	law re as be	Completed								24a. Was autop	an a	24b. Wer	e autopsy r to comple	findings a	vailable
ב ה	siclan: The law certificete has b irector, page 2 s	Con									mear?	deat	th? Yes 2⊑		
2	siclar certif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2₹₹No	The same	Inpatient 2	1 = 10		thor		(Check only o					
5	g Phys er this eral di	-	27. Manner of Death	28a. Date		28b. Time of	IL SLI DOA	4 LI NU		ne 5 🗌 Resid			Specify)		
5	ending leath. or: After he funer	atio	1 ☐Natural 5 ☐ Pendin 2 ☐ Accident investig	gation	iii, Day 19ai)	Injury		onk/ ☐Yes 2☐	No						
18	or Att	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place	e of Injury - At h ling, etc. (Speci	ome, farm, str	eet, factory, office	9	2	28f. Location (S City or Tow		vumber o	or Rural Ro	oute Numb	ber,
-	spital lours a neral filled		29a. Certifier 1 Certifyin	ng Physician: To the	e best of my kno	owledge deat	h occurred at the	time date an	nd place, a	and due to the	rause/s) ar	nd manns	ar as state	d	-
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending; to the preveral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai	(Check only 2 Medical one)	Examiner: On the b	pasis of examination of stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurre	ed at the time, o	date and pl	ace, and	due to the	e cause(s)	
	P S S S S S S S S S S S S S S S S S S S	Σ	29b. Signature and title of certified	1- 1				nse number			29d. Date s	signed (M	fonth, Day	, Year)	
	5		77	muy				00637	738		Mar	ch 2	8, 20	006	
			30. Name and address of person Anjuman Ara, M				Print) Road, S	Silver	Spri	ng, MD	2091	0			
	Sta		31. Date filed (Month, Day, Year)		gistrar's Signa										
	Registr	ar	APR 0	3 2006	Colored .	10 19	100								

		1	For State Registrar		State of I	Maryland					and M		- 6	4.UUb	12027
		an			st)									2006 Year	3. Time of Death 09:30 A M
			ta. Facility Name (If not in	stitution, give	e street and numb	er)				Location of			T		
	Funeral Director		064-32-8905	1				If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day JANUAR)	731	9. Birth <i>Cou</i>	place (State or Foreign intry) NY
	yłand how	-				10c. City	, Town or Lo	cation							10d. Inside City Limits
	he Mar 28a-f si	ector		ENT		ROCI	K HALL		Code				10a.	Citizen of What Cou	1X Yes 2 No untry?
	th with			PEAKE	VILLA RO	AD								USA	
Displaced in Register (Adde) (act) Physician Continued Cont	, etc.														
The Proposition of Control Proposition (Proposition) and the Control Pro	ndustry														
1. Security States (First March Land) Confidence of Death RAPICE 5, 2006 Vasa (3.7 to 1.2 to London of Death MARJORIE MERSON MARJORI MARJ	N														
yland	ould be file Mental Hy arked oth	Be) 					VERA	SCH	EFTEL M	ELI	ENDEZ	
1. Security States (First Motion Land MARJORIE MERSON ART) of the property of	îp Code)														
more,	Pages 1 al ent of Hea nt: If item ry or othe		1 ☐ Burial 2 XCre	mation 3		Cé	emetery, cre	matory or o	ther plac	OION (
Balti	permit. Departm Importa any inju		21. Signature of Funeral	Service Lice	nsee		FF 13	2. Name an ELLOWS 80 SPE	d Addres HI	ELFEN	BEIN CHE	& NEWN	AM N,	FUNERAL I	НОМЕ
	/Medical		Immediate Cause (Final disease or condition	ease, or com ire. List only	a. AEU	th line.	mye							Ą	Approximate Interval Between Onset and Death
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<u>α</u>	es tha igned be de	5		conditions	contributing to dea	ath but not resu	ulting in the u	underlying o	ause giv	en in Part i	l.				the cause of death?
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Vita	siclan: certific rector,	Be	examiner?	medical	Hospital:	notiont 2	EB/Outpatio	nt 2(110)	Oth	05		/	-	e 6 ∏Other /Sner	r/fv1
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)	To th To th comp	Me	29b. Signature and title o	of certifier	2 5)		29	^		230	1	29d.	Date signed (Month	h, Day, Year)
4	ms		30. Name and address of	f person I	MEGA	of death (Item	123a) (Type		152	RD	380		V	ian.	M
:-		28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 32													

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2006 /Medical or Location of Death 4c. County of Death not institution, give street and number) Name (Examiner 8. Date of Birth Month, Day, Y Birthplace (State or Foreign Country) Age (In yrs. last birthday) 6. Sex **Funeral** Min Months Days Hours 1□M 2\ F 85 MD214-12-6111 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ehow the Medical Examiner roust be notified at 1 XYes 2 No MD KENT CHESTERTOWN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21620 USA 109 MANOR AVE. 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural', or itema Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐X\o If Yes, Give Year or Dates: 1 Never Married 2 XMarried Specify: WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7?
Department of Health and Mental Hygiene
Important: If Item 27 is marked other then "nt
any injury or other traumatic event, the Media
once. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARY REBECCA WILLSON SAMUEL IRVING CHANCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 109 MANOR AVE., CHESTERTOWN, MD 21620 LEMUEL R. MCGINNIS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State CHESTER CEMETERY 04/04/2006 CHESTERTOWN, MD 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ovotic Cardio Vascular Disecuse 6 LPAUS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): sate has been signed by the attending physicien page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? Cancer 24a. Was an autopsy performed? After this certificate has 1 ☐ Yes 2 ☐ No 240 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \((Specify) \) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA I Inpatient 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how intury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation after death.

Director: Aft
J in by the fun 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D50996 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person STODDARD 100 BROWN ST CHESTERTOWN MD 37630 MD 31. Date filed (Month, State 3 1 2006 Registrar

		-	For State Registrar	State	of Maryl	and / Depa	artment rtificate					iene _{og. No.}	06	1202	9
			1. Decedent's Name (First, Middle	, Last)							2. Date of Deat Month	h Day	Yeer	3. Time of D	Death
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	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, T					4c. Cot	inty of Dea	th	
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	Funeral		5. Social Security Number 234-30-0941	6. Sex 1 ☐ M 2 ☑ F	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Months		Hours	Min.	8. Date of Birth (Month, Day, Feb. 17	Year)	9. BIT	thplace (State or ountry) Virginia	roreign
Ь	Director	-	Usual Residence of Decedent		0.1						reb. 17	, 152.		viiginia	
	/land		10a. State 10b. County		10c	. City, Town or Lo	ocation							10d. Inside City	
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	h the	Director	10e. Street and Number				10f. Zip 0	Code			1	0g. Citizen	of What Co	ountry?	
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<u>a</u>	Alenta Alenta rked tic ev	To B	Delbe	ert Bragg	Г						Minni	ie Lev	vis		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event. If a Mulfield standard count.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address ((Street a	and Numbe	er or Rui	al Route Number	, City or To	wn, State,	Zip Code)	
Σ.	and and a salth n 27 i		Kenneth L. Mil	Ler (Hus	band)						ra, Mary		219:		
e e	of H		20a. Method of Disposition 1 🗆 Burial 2 🖾 Cremation	3 □Removal from	n State	Db. Place of Dispo cemetery, crea								Town, State	
Ē	Pag ment tant: jury c		' 4 □ Donation 5 □ Other (S	pecify)		R.A. Ferr					04/06	West C	nester	, Pennsylv	rania
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evone.		21. Signature of Funeral Service	n. dag	T NOW	A. Or E	erryvi	Pat ille	terso	on &	Son Fun nd 2190	3-076		P.A.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	t caused the	death. Do not en	ter the mode	of dying	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition	. Car	diac i	arrhy Tr	mia							Oriset and D	oau1
	/Medical Examiner		resulting in death)	Due t	o (or as a cor	nsequence of):	. / /							Typn	~
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	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cax	CO DA C	artc artc sequence of):	- di	40	Le -					years	
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0	that the de led by the a detached f	hys	9 🗆 Unknown								00 000	illi-			a a th ?
	res tha igned l be det	by	Part II. Other significent condition	ons contributing to	death but no	t resulting in the u	inderlying ca	ause give	en in Part	1.		es 2 \square N		robably 4	
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	Fo the	Me	29b. Signature and title of certifie						e number					nth, Day, Year)	
			Carolyn i	Houk M.	0		j	000	51=	720) /	4pnl	04,3	2006	
	3		30. Name and address of person Caro Lyn C+ Hould St. Date filed (Month, Day, Year, APR 0 4 2006	who completed ca	hns Ho	(Item 23a) (Type plans @ R	Print)	Le 1	321 6	elce	Tile Par	leway	, Jui	4014	
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			For State Registrar		State	of Maryland							1	0.00	1200	30
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DIVISION	nding F th.: After e funer	atio				ith, Day Year)	Injury				No					
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	1	For State Registrar				-			e of L				Reg. No	UUb	2 Time of Death
		Decedent's Name (Fi	rst, Middle	, Last)								Month	Day		
		GRACE L	MIL	BOURNE								04			
		. Facility Name (If no	institution	, give street ar	nd number)						of Death		1		
		PRMC						Į.			24 Hrs.	9 Date of Bird			
Physician Committed Comm	Quintry)														
State of Maryland / Department of Health and Mental Hygiens Cartificate of Death Figure 1 Figure 2 Figure 3 Figu															
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The Register of Control of Contro															
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Approximate the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval onsets. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequer ce of): Due to (or as a consequer ce of):															
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	an/I	23b. Was decedent p	regnant onths?	1[Live birth	2 🗌 Feta	death 3			су					
ľ	Sici	1 ☐ Yes 2 ☐ I	No				eatii .	Other (apocity) _						
l	P.		ant condi	tions contribut	ing to death	but not res	sulting in the	underlying	cause g	iven in Par	t I.				
١	р Р	ECRI) -	140			(1	W_) ,			1	Yes 2	!□No 3□	Probably 4 Dinknow
İ	lete	1450	\int									aut	ODSV	prior	to completion of cause of
	E O	VIP C	1//	7								per 1 ☐ Yes	formed? 2⊟No		Yes 2□ No
			d to medic												. 734.
		1 ☐ Yes 2 ☐ N	0		I L_mpa		-		DUA	4 🗆	Nursing H				Specify)
١	on:	1 ⊟Natural	5 Pend	unig	(Month, i	Day Year)		1			□No				
1	a	_	6 ☐ Coul	d not be	e. Place of	Injury - At h	iome, farm,	street, fact	ory, office	θ					r Rural Route Number,
	<u> </u>	4 Homicide	0919	-	building,	etc. (Speci	fy)								
	ertific				n: To the be	st of my kn	owledge, de	ath occurr	ed at the	time, date	and place	a, and due to thurred at the time	e cause(s	s) and manne nd place, and	r as stated. due to the cause(s)
	al Certific	29a. Certifier	Contin	ying Physician	On the hard	s of avamin	ation andio								
	edical Certific	(Check only one)	Medic	al Examiner:	On the basic	s of examin	ation and/oi		7		ar .		29d D		
	Medical Certific	(Check only one)	Medic	al Examiner:	On the basic	s of examin	ation and/oi		7		er (7)	(11	29d. D		
	Medical Certific	(Check only one) 29b. Signature/and t	Medic	al Examiner:	On the bash	s of examin stated.	KAZ	K	7		53,	611	29d. D		
	Medical Certific	(Check only one) 29b. Signature and t	Medic itle of certi	fier on who comple	On the bash and manner	s of examin stated.	A2 m 23a) (Tyi	De, Print)	Dec. Lice	nse numbe	53,	6// and 21	4		
	Medical	29b. Signature and to 30 Name and addres Kazi Kh	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kazi Khan 100 East Carroll Street, Salisbury Maryland 21801												

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Ma	aryland /	-		f Health a of Death	and M		giene Reg. No.	06	12032)
	Physici	ian	Decedent's Name (First, Middle, L.							2. Date of Dea Month	ath Day 3	Year	3. Time of Death	M
>	/Medic		Steve Bowen Mumford 4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death			4		2006 unty of Death	0020	
	LAGIIII		Atlantic General	l Hospital			Berlin				Wo	rceste	r	
) 	Funeral Director		5. Social Security Number 6. 216-70-7358 Usual Residence of Decedent	Sex 7. Age 11☐ M 2☐ F 48	i (In yrs. last b	Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Birt (Month, Day 5/29/19	v. Year)	9. Birth Cou	place (State or Foreigntry) MD	gn
	/land		10a. State 10b. County		10c. City, Tox	wn or Loc	ation						10d. Inside City Limit	İs
90	Man	tor	MD Worcest	ter	Ne	wark							1 ☐ Yes 21∑N	0
	or 28	Oire	10e. Street and Number				10f. Zip Cod	0			10g. Citizen	of What Cou	intry?	
	eth w	rall	8543 Langmaid Ro				2184				US.			
	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Memial Hygiene. A show filem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mast he ricitilied at	by Funeral Director	Never Married 2 Married Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes ② ② N If Yes, Give Year or Dates:		lf i	Yes, specify C	of Hispanic Oric Juban, Mexican No Specify:	, Puerto I	cify Yes or No- Rican, etc.)		Race - Amer Black, White ^{ecify:} Whi	, etc.	
0-00-c	2 hou		15. Decedent's	Education	168	a. Decede	ent's Usual Oc	cupation				of Business/l		
2	thin 7:	Completed	(Specify only highest g Elementary/Secondary (0-12)	grade completed) College (1-4or 5-	+)	(Give k	ind of work do O NOT use re	ne during most tired)	t of workii	ng				
7	e filed within 7 al Hygiene. I other than "r vent, it e med	Con	11			Comme	rcial	Fisherm				food		
yiand	be fill d off	Be	17. Father's Name (First, Middle, La.							(First, Middle,		•		
	12 should be in and Mental in and Mental in its marked or raumatic eve	2	Bowen Sidney Mur 19a. Informant's Name/Relationship		10	h Mailina	Address (Str	Mar eet and Numbe		izabeth			in Codel	
2	d 2 sith and the result traur	1 3	Kathy Lynn Mumfo		19			aid Rd.					p Codej	
ຍົ	t Health t Health itam 27 other tra		20a. Method of Disposition	ord (write)	20b. Place		ition (Name of atory or other		1.00	ate I		on - City or T	own, State	
Ē	Page: ent of nt: #1		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1		pen Cr		4/4/	2006	Fran	kford,	DE	
Daithnor	permit. Pages Department of the important: if its any injury or of once.		21. Signature of Fund I Service Lic		oape 1			dress of Facilit						
۵	Depariment of the parameter of the param		1 Sin 12	whas.		1	08 Wil	liam St	., B	erlin,	MD 21			
F	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mysocardial Tofarction									Approximate Interval Between Onset and Death		
Ē	/Medical Examiner		resulting in death) Due to (or as a consequence of):										minuces	
	LAGITIMIET	١,	Sequentially list conditions,	ic He	c Heart Disease						years			
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	g OI).										
,007	certificate be executed ding physicien and use as the burial-transit	ical Examiner	that initiated events resulting in death) Last	a consequence	onsequence of):									
0	tificat ig phy as the			V										
you .	w requires that the death certifics been signed by the attending pl should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1							23d. Date of delivery Month Day Year			
Ĺ	het th ad by detacl		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?					
ecords,	requires t een signe nould be o	ted by		Hypertension							1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkno			/n
ב ב	or Afrending Physician: The law requires thet the death ifter death. Ifter death. Ifter death. In Control of the sentificate has been signed by the atter in by the funeral director, page 2 should be detached for un.	Completed								24a. Was autop perfor 1 Yes	rmed?	4b. Were aut prior to co death? 1 ☐ Yes	opsy findings availab empletion of cause of 2 No	le
A I La I	ector.	Be	25. Was case referred to medical examiner?	Hospital:			1		of Death	(Check only o	ne)			
5	Phys rthis ral dir	٠ <u>.</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 🗀 Inpatier			SHIDOM			ne 5 Resid			ify)	
5	ding h. After fune	흗	1 Natural 5 Pending 2 Accident investigati	1 □ Natural 5 □ Pending (Month, Day Year) Injury Work?						28d. Describe how injury occurred				
DIVISION OF PROPERTY OF PROPER	N or Atten after deal Directors d in by the	Certification;	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			ral Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) 1									_		
	To the To the comp	Me	29b. Signature and title of certifier				29c. Lic	ense number			29d. Date sig	gned (Month	, Day, Year)	
			LEWS WOOD				D30	619			4/4/2	006		
			30. Name and address of person wh	•			•			r				
D	N 5		Peter S. Abbott					, Suite	1,	Berlin,	, MD 2	1811		
4.3	Sta Reg isti		31. Date filed (Month, Day, Year) APR 0 5	2006 32. Registra	r's Signature	An	de							

		State Registrar	te of Maryland		rtificate o				Rag. No.	IUb	12033
Physici	an	Decedent's Name (First, Middle, Last)					1	2. Date of Death Month Day Y		Year	3. Time of Death
/Medic			Lavada MASO	N			A	April	2, 2	006	0/110 CLM
Examin	er	4a. Facility Name (If not institution, give street a	ınd numb ə r)		4b. City, Town	, or Location of	of Death		4c. Cou	unty of Death	
		14123 Zinnia Lane			Hagerstown					hingto	
Funeral Director		5. Social Security Number 214-34-9664 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day			B. Date of Bir (Month, Da Oct. 1	th Year) 4,1933	9. Birth: Coul Mary	place (State or Foreigi Try) Land
and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation						I Od. Inside City Limits
within 72 hours after deeth with the Maryland ene. then "natural", or items 23s or 28s-1 show ha Madical Examiner must be notified at	៦	Maryland Washington		rsto							1 ☐ Yes 2X ☐ No
the 1	ect	10e. Street and Number	nage	ISCO	10f, Zip Code				100 Citizen	of What Cour	
th with 23a or	0	14123 Zinnia Lane			1742				U.S.A.		
ms 2	Funeral Director	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. V	Was Decedent of f Yes, specify Cu		igin? (Spec	ify Yes or No	- 14.1	Race - Americ	can Indian,
ours after dec al', or items Examiner m	교	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ Yho 1 ☐ Yes 2 ☐ Yho 1 ☐ Yes (3)e Year or Dates:					ican, etc.)	Black, White, etc. Specify: white			
hours tural', al Exe	i by				1⊡Yes 2∑XN	o Specify:					
72 h natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work done during most of work done during most of work done					t of working	7	16b. Kind o	6b. Kind of Business/Industry	
nen Den	d m	Elementary/Secondary (0-12) Col 0-12	lege (1-4015+)								
lygi Tygi nt, I	ပိ	17. Father's Name (First, Middle, Last)		caret	teria-se	,	aula Niama (Cina Middle		public school syster	
ould be filed Mental Hyg arked other atic event,	Be		y Weaver							,	
hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type, Prin		Ob. Maille	- Add (Ot					hoemak	
12 h arr h arr 7 is trau		Donald B.L. Mason - hu	· h		ng Address (Stree						
of Healt item 2		20a. Method of Disposition			3 Zinnia sition (Name of	Lane,	Hage Da			y Land on - City or To	21742
nt of nt of t: if it		1 ⊠ Burial 2 ☐ Cremation 3 ☐ Remova	I from State Come	etery, cren	natory or other pa wn Memor	lace) rial !	April 200			•	
iit. Partme	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral, Service Licensee	5 5		Pa						Maryland
permit. Pages Department of h Important: if ite eny injury or of page.		at m	M	(1/2	Name and Add		LILL		Funera		ryland 217
ysician end springl-transit	Ical Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	true to (or as a consequence true to (or as a consequence true to (or as a consequence	ce oi):							
ures that the death certificate be executed signed by the attending physician end id be detached for use as the burial-Itansi	hysician/Med	in the past 12 months?	es, outcome of pregnancy Live birth 2	ath 3 🗆 5 🗆	Ectopic pregnan Other (specify)			23e. Did t			Day Year
requires een sign rould be	d b			•	,,	,		10	11		ably 4 □Unknowr
The law ete has b page 2 st	Completed						_ '	24a. Was autop perfo 1 Yes	osy rετρejd?	b. Were auto prior to cor death? 1 \(\text{Yes}	psy findings available inpletion of cause of 2 No
Physicien: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?					of Death (Check only o	ле)		
00 S =	2	1 ☐ Yes 2 No Hospital:	1 Inpatient 2 ER/		I JU DOA		rsing Home			Other (Specify	/)
E E E	0	1 Natural 5 Pending	Date of Injury (Month, Day Year)	o. Time of Injury	Work?				curred		
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or Attending Phy after death. Director: After this in by the funeral d	ertificat	4 Homicide determined 259.									
ine nospital or Attending Phy in 24 hours after death. The Funeral Director: After thii pletely filled in by the funeral c	edical Certification;	4 Homicide determined 209. 29a. Certifier (Check only 2 Medical Examiner: On	To the best of my knowled the basis of examination a manner stated.	lge, death and/or inv	occurred at the restigation, in my	time, date and opinion, deat	d place, and th occurred	d due to the at the time,	cause(s) and date and plac	manner as st e, and due to	ated. the cause(s)
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certificat	4 Homicide determined 209. 29a. Certifier (Check only 2 Medical Examiner: On	the basis of examination;	ige, death and/or inv	estigation, in my	time, date and opinion, deat	d place, and th occurred	at the time,	date and plac	manner as st be, and due to aned (Month, I	the cause(s)
I o the nespital or Attending Phy within 24 hours attendeath. To the Funeral Director: After this completely filled in by the funeral of		29a. Certifier (Check only one) Check only one) Additional Examiner: On and	the basis of examination;	dge, death and/or inv	estigation, in my	opinion, deat	d place, and th occurred	at the time,	date and plac	e, and due to	the cause(s)
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			1 - For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of l tificate of	Health and <i>Death</i>	Mental Hygi	iene og. No.	12035	
•			1. Decedent's Name (First, Middle, Last) 2.							h Day Year	3. Time of Death	
	Physici /Medi		JUDY ANN MILLER							31 2006	8:45 A M	
	Examir	ner	4a. Facility Name (If not institution, giv		nber)			or Location of De		4c. County of Death	ATOMONT	
-	Funeral		6320 MONDELL ROAL 5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year		rs. 8. Date of Birth	WASHII 9. Birtho		
	Funeral Director			☐M 2121 F	52	Yrs.	Months Days	Hours Mi	n. (Month, Day, MARCH 3.		place (State or Foreign http) RYLAND	
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County		10a Cit	ty, Town or Lo	ention				10d. Inside City Limits	
	faryla show	50	MARYLAND WASHING	TON.	100. 01	ty, TOWIT OF LO		PSBURG			1 ☐ Yes 2⊠ No	
1213-0036	28a-1	Director	10e. Street and Number	31011			10f. Zip Code	DDOKG	10	og. Citizen of What Cour	ntrv?	
	3e or		6320 MONDELL ROAL)				21782		U.S.A		
	deatl	Funeral	11, Marital Status	12. Was Dece Armed For			Was Decedent of		(Specify Yes or No-	14. Race - Americ Black, White.	can Indian,	
	or Ite		1 Never Married 2 X Married	1 ☐ Yes If Yes, Giv	2 X No 9		1 Tes, specify Cui 1 □ Yes 2 ☑ No		sito rican, etc.,	Specify:		
2-003	hours tural'	ed by	3 Widowed 4 Divorced	Year or Da	ites:	16a Door	fant's Haust Oss	o etion		WI	HTE	
<u>.</u>	n "na	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)	45.)	(Give	ient's Usual Occu kind of work done DO NOT use retin	during most of w	vorking	16b. Kind of Business/In	dustry	
7	d with giene	mo	Elementary/Secondary (0-12)	College (1	·40r 5+)		HOME	MAKER		OWN HON	ME .	
2	2 should be filed within 72 hours after death with the Marylan and Menial Hygiene. Is marked other than "natural", or Items 23e or 28a-f show aumatic event, Ite Medical Exactliner matter went, Ite Medical Exactliner matter.	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle, M	faiden Sumame)		
<u>a</u>	should be nd Mental i marked o	2	RONALD MYERS						. MILLER			
		1 3	19a. Informant's Name/Relationship (MICHAEL W. MILLER				-			City or Town, State, Zip		
	1 and Health Iem 27 other ti		20a. Method of Disposition	C/ SPOUSE	20b. F	Place of Dispo	sition (Name of	1	HARPSBURG,	MARILAND 20c. Location - City or To	21782 own, State	
2	Pages nent of int: If It		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		otate		natory or other pla	1		SHARPSBURG.		
allimore,	permit. Page Department of Important: If any injury or once.	1	21. Sign dure of Fundial Service Lice	1500		22	VIEW CE	ess of Facility	7606 016	l National		
Ŏ	P E E		Tout MI	No Pau	11 M. D	ean B	AST FUNE	RAL HOME		co, Marylan		
	nysician	g P	23a. Part . Enter the disease of com- shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that ca one cause on ea	used the deat ach line.	h. Do not ent	er the mode of dy	ing, such as card	ac or respiratory arre	ist,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):								O	
		e.	Sequentially list conditions, if any, leading to immediate outse. Enter Underlying									
	uted id ansit	Examiner	educe. Enter Underlying Cause (Disease or injury that initiated events c.									
Ď	e exection and and and and and and and and and an	Exa	resulting in death) Last Due to (or as a consequence of):									
0/00,	icate be executed physician and s the burial-transit	edical	d									
0	certific nding p	/Mec	IF FEMALE:	23c. If yes, outo	come of oregon	anov.				1		
O. DO	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes	1 🗀 Live bi	nth 2 ☐ Feta ant at time of d	al death 3	Ectopic pregnand Other (specify)	;y		23d. Date of delive Month	ery D <i>a</i> y Year	
Ĺ	The law requires that the le has been signed by the sage 2 should be detached.	by Ph	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did tob	acco use contribute to the	ne cause of death?	
2	w requires been sign should be								1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown			
necorus,	aw re	Completed							24a. Was an		psy findings available	
_	(0 (1	mo:							autopsy perform	ed? death?	mpletion of cause of 2 No	
VII	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?						eath (Check only one	2)		
5	Physi this c	은	1 ☐ Yes 2 No			ER/Outpatien	1 3 DOA	her: 4 Nursing	-	nce 6 Other (Specif	y)	
	ding l h. After funer	tlon	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Year						28d. Describe how injury occurred			
DIVISION	r Atten ter deat irector: n by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)				eet, factory, office 28f. Location ((Street and Number or Rural Route Number, own, State)		
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edical C	29a. Certifier De Certifying Ph (Check only 2 Medical Exar	ysician: To the niner: On the ba and mann	sis of examina	owledge, death	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as site and place, and due to	tated. o the cause(s)	
	To th withir To th comp									d. Date signed (Month,		
			Mind Ho	mark	rel o	21/1	DI	+647	3 /	April, o	3,2006	
, ,	. 7		30. Name and address of person who	complete cause	of death (Iten	n 23a) (Type,	Print)	210.0			3,2006 1,10 2174	
)h	- 5		31. Date filed (Month, Day, Year)	10 por	gistrar's Signa		130	JAH -	CI. HC	genatow	4/10	
	Sta Registi		APR (13 2	2006	ryiotidi o Olyffa	A. A.	asked		/			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MUWONGE **Physician** ABISAJ MARCH 10.15 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner PIDVENTIST HUSPITAL SHADY GROVE Rockville Montgomerv 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F 88 Yrs. Director 214-37-3404 Aug.14,1917 Uganda Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or iteme 23s or 28s-f show coloai Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Gaithersburg MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 Goodport Court 20878 Completed by Funeral Uganda Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 □ Divorced other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Domestic Home 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be and Mental I Ezekel Kyomubi Musoke Nasalo ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: if Item 27 is any Injury or other training. Eldad Muwonge - Son 14 Goodport Ct Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 4/8/2006 Kyabazala Cem Kyabazala, Uganda 21. Signature of Funeral Service Licen-22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 23a. Part 1. Enter the disease, or complications that caused the death. So not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ACUTE RESPIRATORY PAILURE **Physician** minute disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 days Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed? Yes 2 1 No 20 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 patient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Leath 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:,

completely filled in by the t 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tentifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) adual D0063129 MARCH 29,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 Powlimo Nadkarmi, MD 9901 Medical Center Dr Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State (asals) 04 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 24a per Mary 2855-05/04/06hbeath and Mental Hygians

Amend Item 24 Part Marylane 550 05 and 66 of the alth and Mental Hygiene 1- State AMEND#29d, perMD, 4/4/2006, DPS, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Year **Physician** April 2, Patrick Herbert Manchester 12:24 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise of Montgomery Village Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12XM 2□ F 578-46-2101 70 Yrs. April 5, 1935 Washington, DC Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28e-f show the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Director 10f. Zip Code 20903 10e. Street and Number 10g. Citizen of What Country? 1081 Ruatan Street United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊠Yes 2 □ No 1957 — If Yes, Give Year or Dates: 1959 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk U. S. Postal Service permit. Pages 1 end 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked othe any Injury or other traumatic svent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel H. Manchester Mary Ann Donlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Manchester/ Son 1657 Coopers Way, Frederick, MD 21701 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State April 3, Metropolitan 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crematorium, Inc. rium, Inc. 2006 Alexandria, Virginal Name and Address of Facility DeVol Funeral Home, 10 East 2006 Vircinia 21. Signature of Funeral Service Licenses Deer Fark Drive, Gaithersburg, MD 20877 M0689 23a Part En : the disease, or complications that causemented the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in their failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Liver Disease Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alcoholic Hepatitis Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the ed by the attending detached for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Type II Diabetes, Ascitis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 Yes To the Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 💆 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ŒNaturai 5 Pending Injury after deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral C 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Bay (year) D313 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1 Suhair Abulfarag, M.D. 481 N. Frederick Avenue, Gaithersburg, MD 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 04 Registrar

State of Maryland / Department of Health and Mental Hygierie (1)

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	ži.	1. Decedent's Name (First, Middle, La	ist)			2. Dete of Deeth		Vans	3. Time of I	Death
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	/Medical Examiner	4e Fecility Neme (If not institution, give	ve street end number)		4b. City, Town, or L	ocation of Deeth	4c. County			
	LAAIIIIICI	FUTURE CARE	DIMENTEL MIDST	NG HOME	CLINTON		PRINCE	GEOI	PCE'S	
	Funeral		Sex 7. Age (In yrs. las	st birthday) If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth	Voor	9. Birthpl	lace (State or	- Foreign
м	Director	436-26-1390	^{1□ M 2 ⊠F} 81	Yrs. Months D	eys Hours Min.	8. Date of Birth (Month, Day JULY 30	1924	MISS	TSSIPP	I
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	D = L =	MARTHA W. ANDRE	WS/DAUGHTER	5909 MIDDLI	STON LANE T	EMPLE HI	LLS, MA	KILA	ND 207	40
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we also		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on eech line.	Do not dittor are mode of	dynig, buoir ab buralab	or roopa.ory ao	,	2	Interval Betw Onset and D	veen
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	he Hospital in 24 hours he Funeral pletaly filled edical Co		nysician: To the best of my knowledge: On the basis of examination							}
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			A	/	119431		5/271	106		
1	(2)	30. Name end eddress of person who	completed cause of death (Item 2	(Type, Print)						
K	9	FRANK RYAN M.D.) 11710 LIVINGST	ON ROAD # 1	03 FT. WASH	IINGTON, M	ARYLANI	20	744	
	State	31. Dete filed (Month, Day, Year)	3. Registrar's Signatu							
	Registrar	APR 0 3 200	6 sten &	good						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March 29, 2006 **Physician** 1:00 pM Nielsen Virginia Becker /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1504 Ingram Terrace Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Min 1 M 200 Director 157-26-7706 70 1935 New Jersey Aug. 12, Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1504 Ingram Terrace 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if fem 27 is marked other than "natural; or item eny injury or other traumatic event, the Medical Eventuarions. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High School Guidance Counselor Public High School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Joseph Becker Ruth Elizabeth Burlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Nielsen/ Son 72 West 85th Street, #4A, New York, NY 10024 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State April 3, Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, Mularie MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Atherosclerotic Heart Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I the a detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, Hypertension 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available pnor to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? certificate 2 X No 1 Yes or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 2 1 ☐ Yes 2 🖾 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation s after death. 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09748 D March 31, 2006 Mugne mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Weinstock, M.D 10313 Georgia Avenue, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) Registrar's Signature State 0 3 2006

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Registrar

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	Physici /Medic		Decedent's Name (First, Middle, Later LLA DEAR OFENST)	,					2. Date of Do	Day	Year OO 6	3. Time of Death 5:15AM
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7 %	rs afte	by Funeral	1 ☐ Never Married 2 ☐ Marned 3 ☑ Widowed 4 ☐ Divorced	IX Yes 2 If Yes, Give	:□No es:1944 - 4		I□Yes 2√□No	Specify:			cify: Whi	
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	and 2 aud 2 salth a n 27 le	1	Marlene D. Lombard	0			Deer Trac				27613	
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ω <u>π</u>	tt. Pag rtmen rtent: njury		4 □ Donation 5 □ Other (Specify	y)	Quar		National	1	/10/06	Triang	Le, VA	
B	Dartinoley, Mo permit. Pages 1 and 2 to Department of Health at Importent: If Item 27 le any injury or other trau		21. Signature of Full all Service Licen	10/20			Name and Addre		al Hama	08 Will		
			23a. Part1. Enter the disease, or companies, or heart failure. List only	plications hat cau	used the death.	. Do not ente	er the mode of dyin	g, such as card	diac or respiratory a	erlin,	MD Z	1811 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	as a	17 P		rife.	-0	-20 00			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	ence of):		7	neo-			
		-	Sequentially list conditions if any leading to immediate	b. Due to (or	as a conseque	ance of):	21	-2-2-	7		4	1082-
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Car	N/6-	6	- 1	o and	010	7	1	
Ö	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (o	as a conseque	ence of):			1	Ca, In		2017
8760.	the type at	dicai		d	1							_
9	eath certific attending p for use as		IF FEMALE:	23c. If yes, outco	me of pregnan	nev.						
Вох	death cer attendir	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birtl	h 2 ∏ Fetal on tat time of dea	death 3□	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
Ó.	that the de ed by the detached	Physician/Me	9 Unknown	9□ Unknow								
Division of Vital Records. P.O.	Attending Physicien: The law requires that the death certific redeath. refeath. ettor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	by	Part II. Other significant conditions of	ontributing to deat	th but not resul	lting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use co	ontribute to the	he cause of death?
ord	v requir been si should	eted							_ 10	Yes 2 4No	3 □ Prob	pably 4 □Unknown
Jec Sec	has b	Completed							24a. Was	an 24t	prior to co death?	psy findings available impletion of cause of
<u></u>	icien: The certificate ha	င္ပ	25. Was case referred to medical						1 ☐ Yes	2 No		2 No
<u> </u>	hyeicie this cert al direct	To B	examiner?	Hospital:	eatient 2 E	R/Outpatient	3□ DOA Oth		eath <i>Check</i> on on the control of t	one) dence 6 □C	ther (Specif	(v)
0	ding Ph h. After th funeral	L:Uo	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of (Month,		28b. Time of Injury	28c. Injun Worl		28d. Describe I			7/
sio	Mitendi death. ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No				
D V	after of Direction by	Certification:	4 ☐ Homicide determined	289. Place of	Injury - At hon , etc. <i>(Specify)</i>	n <i>e</i> , farm, stre	et, fectory, office		28f. Location (S City or Tox	Street and Nur vn, State)	nber or Rure	al Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	edical C	29a. Certifier 1 trifying Ph	ysician: To the be	est of my know	rledge, death	occurred at the time	ne, date and pla	ace, and due to the	cause(s) and i	nanner as s	teted.
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and m. nner	r stated.	an server of title	29c. License		souries at the time,			
	7 × 2 8		255. Signatura and this of Certifier	1//			25C. License	870	-8	29d. Date sign	ieu (Montin,	uay, tear)
			30. Name and address of person who o	completed cause of	of death (Item :	23a) (Type, F	Print)	119	1	1/3/	06	
3	T 8+1		WILLIAM ROBINS, M					Y, MD.	21804	100 m		
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signatu	ire						

			For State Registrar	State of M	aryland /		rtment of F		Mental Hy	giene	06	12041
	Physici /Medic		1. Decedent's Name (First, Middle, Calvin Sterl						2. Date of De Month April	ath Day	Year 2006	3. Time of Death 2:30 P M
	Examir		4a. Facility Name (If not institution, Sligo Creek Nur	give street and number)			Location of Dea		4c.	County of Dear	th
	Funeral Director				ge (In yrs. last b	Yrs.	Takoma If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th	Co	ry hplace (State or Foreign ountry) Virginia
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loca	ation		•			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show ricust be notified at	ector	MD Montg	omery	Kens	singt	On 10f. Zip Code			10a Citi	zen of What Co	1 ☐ Yes 27 No
	th with 23a or	al Dir	4000 Spruell Dr	ive			20895			rog. Citiz	USA	ountry r
036	is 1 and 2 should be filed within 72 hours after death with the Manylan of Health and Mental Hygiene. item 27 Is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Medical Exercitien for n	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent	? No		as Decedent of H Yes, specify Cuba	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		14. Race - Ame Black, Whit	
21215-0036	"neture	Completed	15. Decedent' (Specify only highest	s Education grade completed)		(Give k	nt's Usual Occup ind of work done O NOT use retired	during most of w	orking	16b. Kir	nd of Business/	
	filed within Hygiene. other than "	Comp	Elementary/Secondary (0-12)	College (1-4or			Investi	,		U.	S. Gove	ernment
Maryland	ould be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, L						ame (First, Middle	. Maiden	Sumame)	
lary	2 should and Men Is marke	To	Thomas D. O		19	b. Mailing	Address (Street	Marga and Number or F	aret Mae Ru <i>ral R</i> oute <i>Numb</i>	John er, City or	Town, State, 2	Zip Code)
	1 and 2 Health tem 27		Ronald K. Ott - 20a. Method of Disposition	Son	20b. Place	of Disposi	tion (Name of		- Rockvil		MD 2081	
Baltimore,	Pages ment of I ant: If its ury or o		1 Burial 2 Cremation 1 Donation 5 Other (Sp		'	iew C	atory or other plac Semetery	4/5	/06	Во	livar.	WV
Balt	permit. Pages Department of P Important: If ite any injury or of		21. Signature of Funeral Service L	icensee	м97	22.	Name and Addre	ss of Facility Ea	ackles-Sp arpers Fe	ence	r Funer	al Home
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause nly one cause on each	d the death. Do		the mode of dyir				WV ZJE	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		irationsequence	_	rne u	moni	9			Onsot and Jean
	Examiner .	<u>_</u>	Sequentially list conditions, if any, loading to limit ediate	b	Deme	ent	ia					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c. Cer	ebra	1	Athe	2,4050	lerosi	2		
8760,	ate be executed hysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequence	e of):						
9	artificate ing phys e as the	Medic	IF FEMALE:	0.								
O. Box	The law requires that the death certificate be executed tto has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		of pregnancy 2 Fetal deat t time of death		ctopic pregnancy Other (specify)			2	3d. Date of deli Month	ivery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death I	erial	in the und	erlying cause giv			obacco us Yes 2		the cause of death?
_		Completed		Anemia	2				24a. Was autop perfo 1 ☐ Yes	an osy ormed? 2₩ No	24b. Were au prior to death?	topsy findings available completion of cause of 2 No
Viital	Physicien: this certific al director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati	ent 2□ER/C	Duta atiant	all post Oth	er.	eath (Check only o		T0# /0	(4.)
Division of	ding Phy n. After this funeral c	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	28a. Date of Inju (Month, Da	ury 28b.	. Time of Injury	3 DOA 28c, Injun Word M 1 [1/2	Home 5 Resident			eny)
Divis	in it is	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of in	jury - At home, t tc. (Specify)	farm, stree	it, factory, office		28f. Location (: City or Tox		Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifying (Check only one) 1 X Certifying 2 Medicel E	Physician: To the best xaminer: On the basis of and manner st	of examination a	ge, death o	occurred at the tin stigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	h.			29c. Licens	e number	71	29d. Date	signed (Month	n, Day, Year)
1	5		30. Name and address of person w	ho completed cause of	death (Item 23a)) (Type, Pr	int)	1 1	1 1		-01:	4 PARK 4006
	Sta	to	K. Sudhala 31. Date filed (Month, Day, Year)	Cav, MD	rar's Signature	0 (HEROL	LAVE	#230	3, 1	AKOM	40.20912
L	Registr		APR 0 3			Soo	de					

			1 - For Stata Registrar	State of N	Maryland / De C	partment ertificate			and Mental F	lygie Reg.	$\angle UU$	5	2(240
			1. Decedent's Name (First, Middle, Last)					2. Date of				3. Time	of Death
	Physic /Medi		Ann Pratt						Month March	28.		ear	21.	15p M
	Examir		4a. Facility Name (If not institution, give	street and numbe	r)	4b. City, 1	Town, or	Location o			4c. County of	Death		<u> 17</u>
			8041 Fairbreeze I)rive		Sev	ern				Anne A	rund	le1	
	Funeral		Social Security Number 6. Se	x 7. A ∃M 2(X F	Age (In yrs. last birthda	y) If Under Months	1 Year Days	If Under 2 Hours	Min. (Month,	Dav. Ye	ear)			or Foreign
	Director		180-30-7429	141 2(2)	66 Yrs.				March	31,	1939	Virg	inia	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						100	d Inside (City Limits
	Mary	ō	Maryland Anne Arur	nde1	Severn									s 2 No
	28a	rec	10e. Street and Number	IUC I	Bevell	10f. Zip	Code			100	Citizen of Wha	at Countr	v?	
	3s or	<u> </u>	8041 Fairbreeze D	rive			144			1	ited St		•	
	death me 2	by Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S. 1:	3. Was Decede	ent of His	spanic Orig	gin? (Specify Yes or , Puerto Rican, etc.)		14. Race -			
9	or ite	Ē	1 Never Married 2 Married	Armed Forces	5? 1 No				, Puerto Rican, etc.)		Black,	White, et	c.	
93	ours ral',	db	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:	1 ☐ Yes 2	A No	Specify:			Specify:	B1ac	k	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or teme 23a or 28a-f show inth, the Medical Examinar must be rectified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. De (Gi	cedent's Usual ve kind of work . DO NOT use	Occupa k done d	tion uring most	of working	166	. Kind of Busin	ness/Indu	stry	
121	hen hen	ם	Elementary/Secondary (0-12)	College (1-4o	f 5+)									
2	iled v Hygie Ther t		12th 17. Father's Name (First, Middle, Last)		Civi	1 Serv					overnme	nt		
anc	ntal h	Be	Weymouth Savag	· A					ds Name <i>(First, Midd</i> Sell T. Da		den Sumame)			
Maryland	12 should be filed within hand Mental Hygiene. 7 Is marked other than "treumatic event, tre Ma	2	19a. Informant's Name/Relationship (Ty		10h Ma	line Address	(Carrest -		r or Rural Route Nur					
M	ges 1 end 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23s or 28s-f show or other freumatic event, the Medical Examiner must be notified at			Husband		Fairb					Maryla			
ē,	permit. Pages 1 end 2 Department of Health a Important: If Item 27 Is any Injury or other tree		20a. Method of Disposition		20b. Place of Dis	position (Name	e of	1	Date	-	. Location - Cit			
Baltimore,	Pages nent of I int: If It		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stat	θ	ematory`or oth		1	4/5/2006	1				
ij	ortar		21. Signature of Funeral Service Licensi	90 /					4/5/2006		neltenh			and
B	permit. Departr Importe any Inju		1/hatte k	u la	-0	Alexand	der erlb	S. Po	pe Funera ike Fores	1 Hc	omes, P	·A.	<i>1</i> .7	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that cause	ed the death. Do not e	nter the mode	of dying	, such as o	ardiac or respiratory	arrest,	LIE, IIG	A	pproxima	ite
	Physician		Immediate Cause (Final	ne cause on each	X X X	1 /		w	Carrela	,			nterval Be	
	/Medical		disease or condition resulting in death)	Due to (or a	s a consequence of):	40	w	7	(-	ye	ay
Н	Examiner												•	
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initial property)	Due to (or a	s a consequence of):									
	nd nd transi	Examiner	that mitiated events									10		
, 0	e exe sian a urial-	EX	resulting in death) Last	Due to (or a	s a consequence of):									
8760,	The law requires that the death certificate be executed tie hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai		l										
9	eath certific attending p	Med	IF FEMALE:											
Вох	ath c	ian	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pre					23d. Date of Month	f delivery Da		Year
-	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐ Unknown	at time of death 5	Other (spec	cify)			-	MONTH	D	ау	T G al
P.0.	that the ed by detac		Part II. Other significant conditions con	tributing to death	but not resulting in the	underlying car	USA CIVAL	n in Part I	23e Die	1 tobacc	o use contribu	to to the	cause of	doath?
Vital Records,	sign d be	d by	Found Heit A	un a	raternal) (111	e Co			37		ly 4 🗆	
Ö	w requir	Completed	MM SI	12 elles)						
Re	The lav	Ē	1-0.00	rouce					24a. Wt	is an lopsy rformed	24b. Wer	e autopsy to comp	y findings letion of a	available cause of
a			05.00						1 ☐ Yes		No 1	Yes 2	□ No	
	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital:			Other		of Death (Check ont)				-	
ō	Physic this stal di	-	1 ☐ Yes 2 X No	i ∐ Inpat				4 🗀 ivur:	sing Home 5 Re		6 Other (Specify)		
on	ding th. th. After funer	후	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D	ay Year) Injury	м Е	c. Injury : Work?	es 2∐N		5 110 W II	ijury occurred			
Division of	Attending r death. ector: After by the funer	ffca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir	njury - At home, farm, s					(Street	and Number o	r Aural A	oute Num	.ber
ā	a after	Certification;	4 Homicide	building, e	tc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or T	own, St	ate)			.507,
	Hospitel 4 hours a Funerel [ely filled		29a. Certifier 1 Certifying Phys	ician: To the bes	t of my knowledge, dea	th occurred at	the time	, date and	place, and due to th	e cause	(s) and manne	r as state	ed.	
	To the Hospitel or Atti within 24 hours after de To the Funerel Directi completely filled in by the	edicai	(Check only 2 Medical Examinone)	er: On the basis and manner s	of examination and/or i	nvestigation, ii	n my opii	nion, death	occurred at the time	a, date a	and place, and	due to th	e cause(s)
	within To t	Σ	29b. Signature and title of centrier	20/1	A	29c.	License	number		29d. I	Date signed (M	fonth, Da	y, Year)	
•			TINULI	Mer	1399	D	2143	38		Ap	oril 3,	200	6	
0	(6)		30. Name and address of person who co							0 1 1 -				
			Michael J. LaPent		5 Defense	Hwy. Ar	nap	olis,	Maryland	2140)1			
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2006	2. Regist	rar's Signature	de								

			For State Registrar	State of		id / Depa		t of H	ealth a		ental Hyg		0 6	1204	3
	Physici		1. Decedent's Name (First, Middle, I Eleanor P. Pry								2. Date of Dea Month March	Day	Yeer	3. Time of De 4:30	a a M
	/Medic Examin		4a. Facility Name (If not institution, G	ive street and num				Town, or	Location o	f Death	Halen	4c. Cou	inty of Death		
	Funeral Director		5. Social Security Number 6 214-10-9727 Usual Residence of Decedent	Sex 1 □ M 2 □ X F	7. Age (In yrs. 90	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 11/25/	, Year)		plece (State or Fi intry) ryland	'oreign
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Modical Examiner must be multiled at	Director	10a. State 10b. County Delaware Susse 10e. Street and Number	ex		y, Town or Lo Delmar	10f. Zip					l0g. Citizen (of What Cou	10d. Inside City L 1 Yes 2	
336	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic svent, the Modical Examiner must be multiled at once.	by Funeral	8 Golden Lane 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Dece Armed For 1	ces? 2 2 No	ì			spanic Orig n, Mexican	gin? (Spe , Puerto i	ocify Yes or No- Rican, etc.)	В	Race - Ameri Black, White, cify: Wh:	, etc.	
21215-0(d within 72 hou giene. sr than "natura i the Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed) College (1-	4or 5+)	16a. Deced (Give life. I	kind of wor DO NOT us	k done d e retired)	uring most	of worki	ng		f Business/Ir	ndustry	
/land	should be fited ind Mental Hygid smarksd other umatic svent, II	To Be (17. Father's Name (First, Middle, La Ira Payne	st)					18. Mother Edi		(First, Middle, Parsons	Maiden Sum	name)		
, Mar	is 1 and 2 sho of Health and Item 27 is my other trauma		Pat Pryor/daugh			1111	Haye	es Av	7e., S	Sali	sbury, l	MD 218	304		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1										rk, DE		.on
	Physician /Medical Examiner	ilner	23a. Part1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to (c	used the deat ch line. Cum or or as a consequent	h. Do not ent							ID 2180	Approximate Interval Betwee Onset and Dea	en
). Box 68760,	death certificate be executed he attending physician and ed for use as the burial-transit	Physiclan/Medicai Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	th 2 Feta int at time of d	ancy	Ectopic pro						Date of deliv	ery Day Yea	ar
Records, P.O.	The law requires that the death certifica site has been signed by the attending ph bage 2 should be delached for use as th	Completed by Phy	9 ☐ Unknown Part II. Other significant conditions			sulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	es 2 No	o 3 ☐ Prol	the cause of deat bably 4 Unk	cnown
Vital R	ian: The srtificate hi ctor, page	Ве Сош	25. Was case referred to medical examiner?						26. Place	of Death	perfor	med? No	death? 1 ☐ Yes	2 🗆 No	
Division of V	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To	1 Yes No 27. Magner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine	28a. Date o (Month	f Injury , Day Year)	ER/Outpatien 28b. Time of Injury ome, farm, stre	M 2	Bc. Injury Work 1 🔲 Y	at Nur	No.	ne 5 Resid 28d. Describe h 28f. Location (S City or Tow	ow injury occurrent and Nu	curred	fy) al Route Number	r.
Ω	Hospital of the policy of the	Medical Cer	29a. Centifier (Check only one) Certifying Medical Expone)	Physician: To the aminer: On the baand mann	sis of examina	owledge, death	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the ded at the time, o	ause(s) and late and plac	manner as s	stated. o the cause(s)	
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	000	MS			License	number	78		9d. Date sig	ned (Month,	Day, Year)	
	Sta		30. Name and address of person when the second seco	Like Co	of death (Iter	p)U	Print)	Box	173	3	Solisi	5,	nD	2.180	2
DH	Registr IMH 17 Rev 1/2		All O I	2000	Merco	ORIGIN	AL	95 65				-		- CITE	

				1- State of Maryland / Depart Registrar Certifi	ment of Health and I ficate of Death		giene	6	12041;
				Decedent's Name (First, Middle, Last)		2. Date of Dea Month		Vasa	3. Time of Death
		Physici /Medio		Mattie Roberts		March		Year 106	7:44 a M
		Examir			b. City, Town, or Location of Death	h	4c. County	of Death	
				Suburban Hospital	Bethesda f Under 1 Year If Under 24 Hrs.	0.5 (5:4)		gome	
		Funeral Director			Honths Days Hours Min.		2,1928	9. Births Cour Alal	place (State or Foreign otry) Dama
		and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	ion				0d. Inside City Limits
		atter deeth with the Marylan or Iteme 23a or 28a-f show minst must be notified at	ŏ	MD Prince Georges Mitchelly					1X Yes 2 □ No
		r 28a	rec	10e. Street and Number	10f. Zip Code		10g. Citizen of V	Vhat Cour	ntry?
		th with	a D	1423 Albert Drive	20721		USA		
		r dee	iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces?	s Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puert	Specify Yes or No- to Rican, etc.)	14. Race Blace	e - Americ k, White,	ean Indian,
	36	should be filed within 72 hours atter deeth with the Maryland nd Mental Hygiene. w marked other then "naturel", or iteme 23a or 28a-f show umatic event, Ire Modical Examinar must be notified.	Completed by Funeral Director	1 □ Never Married 2⊠ Married 1 □ Yes 2 ☒ No	Yes 21 No Specify:			Bla	
	9	2 hou	ted	15. Decedent's Education 16a. Decedent	t's Usual Occupation		16b. Kind of Bu		
	215	d within 72 ho piene. r then "natu	ple	(Specify only highest grade completed) (Give kind life. DO	d of work done during most of wor NDT use retired)	rking			,
	2	ed wil	Соп	4yrs Home	Economist		Govern		
	Maryland 21215-0036	be filed ntal Hygi od other event, II	Be	17. Father's Name (First, Middle, Last) Joe Smith		me (First, Middle, i	Maiden Sumam	e)	
	Ž	hould d Mei mark	2		Sarah Address (Street and Number or Ru	Dixon	r City or Tour	State 7in	Codol
		nd 2 sulth an 27 ie 27 ie r trau			lbert Dr., Mitch				Code)
	re,	is 1 ar		20a. Method of Disposition 20b. Place of Disposition	on (Name of		20c. Location -		own, State
	Ē	Page nent o ant: If ury or		1 ES Dunai 2 Cremation 3 Chemoval from State	ON CEMETERY 4/4	/2006	CLINTO	N,MAH	RYLAND
7	Baltimore,	permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 ie marked other eny injury or other traumatic event, 2002.			ame and Address of Facility Landover Rd.,			eral 0785	Home
X	E			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. Usist only one cause on each line.	he mode of dying, such as cardiac	o or respiratory arr	est,		Approximate Interval Between
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4		/Medical Examiner		resulting in death) Due to (or as a consequence of):					4 4 14 5
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7	٦,	res that igned b be deta	by Pt	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tol	bacco use contr	ibute to th	e cause of death?
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0	of Vital Records,	e law re hes be	Completed			24a. Was a autops	n 24b. V	Vere auto	psy findings available npletion of cause of
6	<u>~</u>		Сод			perforr	mea? a	eath?	2 🔏 10
	Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		ath (Check only on	10)		
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7	ion	Attending F r death. ctor: After by the tuner	atlor	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	-	
3	Division	r Attender death rector:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (St City or Town	treet and Numbe	or Or Rura	l Route Number,
3000		urs aft ret Di							
Re		To the Hospital or Attent within 24 hours after death To the Funerel Director: completely tilled in by the	Medical	29a Certifier (Check only one) Carthying Physician: To the basis of examination and/or invest and manner stated.	numed at the trace, date and place igation, in my opinion, death occu	, and due to the earned at the time, do	auss(s) and ma late and place, a	nd due to	ated. the cause(s)
		To t To t	Σ	29b. Signature and little of certifier	29c. License number		9d. Date signed		
	•		3	I'W M	D51652	1	March	27,	2006
(1	10	- 0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print Matth & Poffcorth MD 990(A	D51652 Medical center	105-	1	n	m 2 nem
•		Sta	te	31. Date filed (Month, Day, Year)	nenical Level	V-156	1-06 4-01	7,1	שנפטש עה
		Registr	ar	GOD & 3 3AAA Delen & Span	٤٠				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician March 29, 11:30P M 2006 baum /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner #727 Rockville Montgomery 10500 Rockville Pike If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Y DEC. 10, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 063-20-5482 1 XM 2 F Yrs. 1915 90 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show many injury or other traumatic event, the Medical Exportrer must be notified at once. 1 XYes 2 No Rockville Maryland Montgomery Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20852 United States of America 10500 Rockville Pike #727 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Types 2 No
If Yes, Give
Year or Dates: 1945-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lawyer Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Cohen Herman Rosenbaum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) **#505**, Bethesda, MD 20816 4990 Sentinel Drive James Rosenbaum - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Judean Memorial Gard, 04/02/06 Olney, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature of Euneral Service Licensee Silver Spring, MD 20904 11800 New Hampshire Ave, 23a. Part 1. Expert the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner after death.

after death.

I Director: After this certificate has been signed by the attending physician and 1 in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Uhrknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 Yes 2 1 NO Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 → esidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 4005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (, Cate Ct Woodbin and 21797 DICHOROL 3250 31. Date filed (Month, Day, Year) Registrar's Signature 0 3 2006 Registrar

			1 = For Stata Registrar	State of Mary		artment o				giene	6	12046
		М	Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
₹.	Physici /Medio		Elsie H. Rasmuss	en					Month March	30, 200	Year 06	1:00 p.M.
	Examir		4a. Facility Name (If not institution, give s.			4b. City, Tow	n, or Location of	of Death			y of Death	
*			30 Locust Street	Apt. 109		TuTo.	atminat	-016			Carro	11
48	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Ye Months Da	stminst ear Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v Year)	9. Birth	place (State or Foreign
	Director		579 - 38 - 8802	м 2√2 F	83 Yrs.	MOTHETS Da	lys Hours	IVIIII.	March	6 1923		MD
	pu ×		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	nation					т	10d. Inside City Limits
	aryla ehov	5			,	-						1 Stress 2 No
	Ne M	Director	MD Carro)TT	Westm	inster						
	with t	급	10e. Street and Number	+ 7m+ 100		10f. Zip Cod				10g. Citizen of		intry?
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Itema 23a or 28a-f show matic event, the Medical Examinar must be notillised at	Funerai	30 Locust Stree	2. Was Decedent Ever	-110		21157	-:-0 (0-	- 4 V N -		SA	and the state of
	ter de	Ľ,	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 Yes 2 XNo		Was Decedent of If Yes, specify C	of Hispanic Off Cuban, Mexicar	n, Puerto	Rican, etc.)		ce - Amen ck, White	ican Indian, , etc.
36	I', or	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	No Specify:			Speci	fy:	White
21215-0036	thou stura	ed	15. Decedent's Educ		16a, Dece	dent's Usual Oc	cupation			16b. Kind of E	Business/Ir	ndustry
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212	iene piene r the	E	Elementary/Secondary (0-12)	College (1-4or 5+)	P	none Ope	erator			Police		
פַ	illed Il Hygi other	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	(First, Middle,	Maiden Suma	me)	
ā	Mental Mental arked o	ToE	Jerome L. Michael				Mar	ylan	d V. Ta	ylor		
Maryland	w = = 3	_	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Str	eet and Numbe	er or Rura	I Route Numbe	r, City or Town	, State, Zi	p Code)
	and 2 Balth a n 27 ls		William Rasmussen/	son	614	Klees M	ill Rd	We	stminst	er. MD	211	57
re	of He of He fiter		20a. Method of Disposition		b. Place of Dispo	sition (Name of matory or other	f place)		Date	20c. Location	- City or T	own, State
Ĕ	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		rovidenc			3/31	/2006	Gamber	- MD	
Baltimore,	permit. Page Department of Important: if any Injury or once.		21. Signalu e of Funeral Service License			Name and Ad						
ñ	Depa Impo		John K Phyl	-		112 Wash	hington	Roa	e and C	mineter,	· MD	21157
	1		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the							-	Approximate Interval Between
	Physician		Immediate Cause (Final	D. T	- T.							Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor	sequence of):	4						2 weeks
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	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o Î	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a cor	sequence of):							
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9	tifica ng ph as th	led										
ROX	death certifi e attending I id for use as	by Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pro 1 ☐ Live birth 2 ☐		∃Ectopic pregna	an ou			23d. Da	ate of deliv	rery
	0 0 0	icie	in the past 12 months?	4☐ Pregnant at time 9☐ Unknown		Other (specify				M	onth	Day Year
J.	by the	hy	9 Unknown						-			
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ğ	w require been si should t		End Stage R	my pour	sease,	COOL	0000	4	1 🗆 Y	es 2 No	3 Pro	bably 4 Unknown
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Ĭ	: The law cate has I	Completed	1						autop perfor	med? 2/2/No	death?	ompletion of cause of
Vital Hecords,	iclan: Th certificate rector, pag	a	25. Was case referred to medical			NEV COLUMN	26. Place	of Death	Check only o			20 110
	nysic alis ce direc	To B	examiner? 1 ☐ Yes 2 ☐ No	ospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA	Other: 4 Nu	ırsing Hor	me 5/1/Resid	lence 6 🗆 Ot	her (Speci	fy)
וס ר	ding Ph h. After thi funeral		27. Manner of Death 1. ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	28c. l	njury at Work?	2	28d. Describe h	ow injury occu	rred	
DIVISION	tendir Jeath. tor: Af the fu	atic	2 Accident investigation	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , ,		1 ☐ Yes 2 ☐	No				
≝	st or Attendit after death. I Director: Al d in by the fu	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, offi	се	2	28f. Location (S City or Tow		ber or Rur	al Route Number,
	ital o	Certification:										
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificiality filled in by the funeral director.	edical	29a. Certifier 1 ☐ Certifying Physi (Check only 2 ☐ Medicat Examin	ician: To the best of my er: On the basis of exar	knowledge, deat	n occurred at the	e time, date an	d place, a	and due to the	cause(s) and m	anner as s	stated.
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Medi	Oriej	and manner stated.								
		~	29b. Signature and title of certifier	: 11			ense number			29d. Date signe		
	MIL		Mach	mothers		l on	1141	05		Was	vek	50,2000
	10		30. Name and address of person whe cor	ries Hens	² MD ^{Type} ,	Print) کا	e Ron	in-	Rin	~ =	- 0	30, 2000
248	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	ignature	- 1 W	1-24.1	21143	1-415	110	ony x-	me ciri

Registrar

APR 0 3 2006 Security of APR 0 3 2006

Certificate of Death

1 - For Stata Registrar

			1. Decedent's Name (First, Middle, I	ast)				2. Date of De			3. Time of Death
	Physic /Medi		Carl Foster Rour	nds				Month 04	Day O		18:40 M
1 ch	Examir		4a. Facility Name (If not institution, g	ive street and number)		4b. City, Town, o	r Location of Dea	ıth	4c.	County of Death	
			SACRED HEAR	T HOSPITAL		COME	SERLAND	•		ALLEG	YNA
	Funeral			Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th Vear	9. Birth	place (State or Foreign
	Director		217–14–4281	1 X M 2□ F 8	2 Yrs.	Working Days	TIOUIS NIII	April 2	24, 1	.923 Ma	ryland
	DG ***		Usual Residence of Decedent 10a, State 10b, County	100 C	ity, Town or Lo	action					104 1 02 11 2
	ehow	5									10d. Inside City Limits 1 ☐ Yes 2 X No
	the Mary 28a-f eh	Director	MD Garrett 10e. Street and Number	Gra	ntsvil						10-
	€ 9 %	눔	10456 New German	D.2		10f. Zip Code			_	zen of What Cou	ntry?
	death w	Funerai		12. Was Decedent Ever in L	10 10	21536		2 7 17 11	USA		
	after d or item	Š	11. Marital Status 1 □ Never Married 2 🕅 Marned	Armed Forces?		Was Decedent of H If Yes, specify Cuba	in, Mexican, Pue	specify Yes of No into Rican, etc.))-	 Race - Ameri Black, White, 	
36	ours aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW2		1 ☐ Yes 2 🔀 No	Specify:			Specify: W	nite
Maryland 21215-0036	n 72 hours after "natural", or ite	ed	15. Decedent's	Education	16a. Dece	dent's Usual Occup	ation	-	16b. Kir	nd of Business/In	dustry
7	thin 7:	pie	(Specify only highest of Efementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	durina most of wi	orking		re Brick	
21,	₹ <u> </u>	Completed	7	College (1-401 5+)	Pres	s Operato	or		Man	ufacture	9
Þ	othe othe	Be	17. Father's Name (First, Middle, La	st)			18. Mother's Na	ame (First, Middle	Maiden .	Sumame)	
<u>Ja</u>	uld b Ments irked	To	Floyd Rounds				Sarah J	ane Broa	dwat	er	
an	and h	ľ	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or	Town, State, Zip	Code)
	ss 1 and 2 should be filed of Health and Mental Hyg Item 27 is marked othe other traumatic event,		Edith M. Rounds/	Wife	10456	5 New Gern	many Rd.	, Grants	vill	e, MD 2	21536
ore.	of He		20a. Method of Disposition	1 .	Place of Dispo	sition (Name of matory or other place	(e)	Date	20c. Lo	cation - City or To	own, State
Ĕ	ertment of crtant: if it injury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	city) Gra	ntsvil	le Cemete	ry Apri	1 12,200	6 Gra	antsvill	e, MD
Baltimore,	permit. Peges Dept rtment of Important: If I any injury or once.		21. Signature of Furieral Service Lic	ensee		2. Name and Addres					P.A.
_	80 E 5 8		No Jeuste	image)	I I	P.O. Box 2	275, Gra	ntsville	, MD	21536	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the dea	th. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Setween
d	Physician		Immediate Cause (Final disease or condition	myorate	liali	ntari	tiun				Onset and Death
4	/Medical		resulting in death)	Due to (or as a consec			1				
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	and trans	Examiner	Cause (Disease or infury that initiated events resulting in death) Last	с							
90,	oe ex cien a	Ē	Todaking in dodkiny bask	Due to (or as a consec	quence of):						
68760,	eath certificate be executed attending physicien and for use as the burial-transit	cian/Medicai		d							
9 ×	ding	/Me	IF FEMALE:	23c. If yes, outcome of pregna	2001						
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta	al death 3□	Ectopic pregnancy			2	 Date of deliver Month 	ery Day Year
P.O.	the d	Physic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of c 9□Unknown	Jean 3L	Other (specify)	-				
٦	The law requires thet the de ute has been signed by the a bage 2 should be deteched i	된	Part If. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco us	se contribute to the	ne cause of death?
sp.	uires n sign ld be	d by						10	Yes 2□	No 3 □ Prob	ably 4 Unknown
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Re	he la e has ige 2	E C						autor		prior to co death?	psy findings available mpletion of cause of
a	in: T	ပိ	25. Was case referred to medical					1 ☐ Yes	2☑ No	1 🗆 Yes	2 No
>	sicis s cert lirect	To B	examiner? 1 1 Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatien	• 3D DOA Othe		ath (Check only o			
o	Phy er this	-	27. Manner of Death	28a. Date of Injury	28b. Time of	1 3 DOA	4 Nursing	Home 5 Resid			γ)
Division of Vital Records,	nding tth. :: Afte	tio	1 □ Maturaf 5 □ Pending 2 □ Accident investigati	(Month, Day Year)	Injury		(? Yes 2 □ No				
Vis	Atte	Hice	3 ☐ Suicide 6 ☐ Could not determine	289. Place of injury - At n	ome, farm, str	eet, factory, office				Number or Rura	Il Route Number,
Ö	s afte	Certification:	4 Difference	building, etc. (Specia	Y)			City or Tov	vn, State)		
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	cai	29a. Certifier 1 Certifying F	hysician: To the best of my kno	wledge, death	occurred at the tim	e, date and plac	e, and due to the	cause(s) a	and manner as s	tated.
	the H in 24 the F iplete	edicai	one)	miner: On the basis of examina and manner stated.	ition and/or inv	restigation, in my op	oinion, death occ	urred at the time,	date and p	place, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License	number		29d. Date	signed (Month,	Day, Year)
			Nomon & W	engs		1)(19331		apx,	110 3	006
4	AVA		30. Name and address of person who		п 23а) (Туре,	1,00	. 0.		-	w.05	
(, ,		1443/406	ED ROAD NI	5 (1	1 myckla	NO INC	MICHO	2	1502	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	2 . DE C					
	Registr	ar	AFR II	2000	AN ME						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Hensley ROBINSON Madeline March 2006 9:10a.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Homewood at Williamsport Williamsport Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Sept. 18,1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 🔀 F 82 234-24-4745 West Virginia Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show r then "naturel", or items 23a or 28a-f shov the Medical Exemitment the notified at Maryland Washington Hagerstown 1X Yes 2 ☐ No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 830 Washington Avenue 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene. other then "naturel", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☒ No þ Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 0-9 College (1-4or 5+) clerk typist aircraft manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ages 1 and 2 should be fill out of Health and Mental H Jerry Mack Hensley Bertha Lee Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Robinson - son 121 West Side Avenue, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Memorial April 2006 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home nel L. Nestal 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) CNO Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 the attending physicien Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Day in the past 12 months?
1 Yes 2 No Month Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes Division of Vital 20 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check only on 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mariner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending death. 1 Yes 2 No 2 Accident investigation after death the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: Te the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signate 29c. License numbe XCA mpl d cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Yar) State Registrar

		1	For State Registrar	State of Ma		artment <i>rtificate</i>			ınd M		iene eg. No.)6	12049
			1. Decedent's Name (First, Middle,							2. Date of Dea Month	Day	Year	3. Time of Death
	Physici: /Medic	al	Robert Franklin							April		2006	11:10 P M
ı	Examin	er	4a. Facility Name (If not institution, 11413 Manse Roa	ıd			gers	town			Wasl	hty of Death	on
	Funeral Director		215-20-7520	5. Sex 7. Age 12⊠ M 2□ F 8.	(In yrs. last birthday, Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 02/15/	Year) 1925	9. Birth	place (State or Foreign ntry) MD
	and ow	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation							10d. Inside City Limits
	Mary I sh	to	MD Washir	ngton	Hagers	town							1 ☐ Yes 2 X No
	with the 3a or 28s	I Director	10e. Street and Number 11413 Manse Roa	ıd		10f. Zip (740				10g. Citizen d US	of What Cou	ntry?
36	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-1 show fra Madical Examiner must be mouthed at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decede If Yes, specif		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		lace - Ameri Black, White, cify: Wh	
Maryland 21215-0036	i within 72 hou jiene r than "nature ine Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 54	(Give	edent's Usual e kind of work DO NDT use Repa	done d retired	ition luring most	t of worki	ng		Business/Ir	
and 2	be filed ital Hygi od other event, I	Be	17. Father's Name (First, Middle, L. Fred William Ro							(First, Middle, ra (unk			
Mary	and and and and and	2	19a. Informant's Name/Relationshi	p (Type, Print) C / Wife	19b. Mail 114	ing Address 13 Man	(Street a	Road,	or or Rura Hag	al Route Numbe erstown	r, City or Tov , MD 2	vn, State, Zi 1740	p Code)
d)	ages 1 and 2 ant of Health at: If item 27 i y or other tre		20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 1 ☐ Donation 5 ☐ Other (Sp.		20b. Place of Disp cemetery, cre Smithsbu	ematory or other	her place			/2006	20c. Location	•	
Baltir	permit. Pages Department of h Important: If ite any injury or of		21. Signature of Funeral Service L		/	22. Name and	d Addres	s of Facilit	y Ge	-	Minni	.ch Fu	neral Home
1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_aLVN	the death. Do not ene.								Approximate Interval Between M P 1
8760,	ate be executed thysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):								
P.O. Box 68	Attending Physician: The law requires that the death certificat refabl. In death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pre						Date of deliv Month	very Day Year
ds, P.	uires that the dea signed by the ai Id be detached fo	þ	Part II. Other significant condition	ns contributing to death bu	at not resulting in the	underlying ca	use give	en in Part I			obacco use c ∕es 2□No		the cause of death?
I Records,	The law requir ate has been si page 2 should I	Completed		1						24a. Was autop perfo 1 - Yes		b. Were aut prior to c death? 1 \(\text{Yes}	topsy findings available ompletion of cause of
Vital	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	0.00		h (Check only o		Oth / C	
of	Phys r this ral dir	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie			8c. Injun Worl	4 🗀 🕅	irsing Ho	me 5 L esi 28d. Describe l			any)
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1	ation ot be 390 Place of Init	ury - At home, farm, s	М	1 🗆	Yes 2 🗆	No	28f. Location (City or To		ımbe r o <i>r R</i> u.	ral Route Number,
J	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying (Check onl) 2 Medical E	g Physician: To the best of examiner: On the basis of and manner sta	examination and/or	ath occurred a investigation,	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and plac	I manner as ce, and due	stated. to the cause(s)
1	within To the Comple	Me	29b. Signature and title of certifier	S. NII	USTI	290	Licens	e number	04	3	29d. Date si	gned (Month	n, Day, Year)
4	(St)		30. Name and address of pers 70	who completed cause of d	eath (Item 23a) (Typ	Print)	RI) ,	1/1	PERS	TUWI	VM	D 21742
	St Regist	ate rar	31. Date filed (Month; Day, Year)	2006 Registra	ar's Signature	will							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician 2006 4:00 AM REYNOLDS TRVTN H. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS HOSPITAL PRINCE GEORGES LANHAM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**X** M 2□ F Director Yrs. 401-28-8230 85 JULY 18,1920 KENTUCKY Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location ral', or iteme 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits Director 1▼ Yes 2 No PRINCE GEORGES MD. UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9115 MARLBORO PIKE U.S.A. 20773 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 📉 No ð Specify Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 DIESEL MECHANIC GRAYHOUND BUS CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS REYNOLDS GRACE WHALEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as important: If item 27 to eny injury or other trau JACOB WARNER/COUSIN 116 ROSEWOOD DR., GREENBELT, MD. 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 4-4-2006 RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 6 Examiner Due to (or as a consequence of): burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Certification: To Be Completed by 2 No 1 Tyes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificete 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After the 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner. On the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s), and manner stated. Medical 29a. Certifier the 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD3135 cause of death (Item 23a) (Type, Print) Good Luck Rd Lanham, MD 20706 inda 31. Date filed (Month. 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year DONALD GEORGE STALLINGS II APRIL 10, 2006 2:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 613 WATERWHEEL LANE ANNE ARUNDEL MILLERSVILLE 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1√2 M 2□ F Director 52 OCT.01,1953 MARYLAND 213 64 4949 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Meulcal Exartmet must be notified at 1 ☐ Yes 2 ☐ No MARYLAND ANNE ARUNDEL MILLERSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be liled within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat; or Items 23s any injury or other fraumatic event, the Medical Example once. 613 WATERWHEEL LANE Funeral 21108 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No ff Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) 12 0 PLUMBER PRINCE GEORGES'S CO. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) ပ DONALD G. STALLINGS VERA ALBERTA WAGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELISSA V. MILLER (DAUGHTER) 6330 BAYVIEW DRIVE TRACYS LANDING, MD. 20779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY GLEN BURNIE, MD. 04-13-06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD 21037 EDGEWATER, MD 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) DANCreas 4 Month concer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physiclen a for use as the burial-Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an has le 2 autopsy performed? page 1 Yes 2 3NO To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA (his 28a. Date of Injury (Month, Day Year) Alter thi funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 1X Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DØØ57802 APRIL 11,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Messersmith 401 North Broadway, Baltimore, Maryland 0, MA 31. Date filed (Month, Day, Year) 32 Rigistrar's Signature State Registrar 2006

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Clayton William Smith March 28, 2006 1752 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. 1₽M 2□ F 212-15-9825 31 Yrs. Director 1974 Washington, D.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "neturel", or Items 23s or 28s-f ehow the Madical Examinar must be notified at District Heights **Funeral Director** 1 X Yes 2 No Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2020 Brooks Dr. #306 20747 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) WEB Manager Private Industry other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be fill of Health and Menta! H William H. Smith, Jr. Darlene Tarpley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020 Brooks Dr. #306 District Heights, Md. William H. Smith, Jr. /Father Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or one Harmony Memorial 4/3/2006 Landover, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Alexander of acili Pope Funeral Homes, P.A. PT 01 083 5538 Marlboro Pike/Forestville, Md..20747 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cete hes been sig , page 2 should b 1 Yes 2√2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2∄No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 X Inpatient Medical Certification; To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 2 ☐ Accident 5 Pending after death. investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specily) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7610 Carol Ave. Takoma Park, Md. 20912 MASREEN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State APR 0 3 2006 Registrar

				State of Maryland	d / Depa	artmen	t of H	ealth a				n 6	1205	3
			Registrar		Ce	rtificat	e or L	Jeath	- 10		Reg. No.		O Time of De	
	Physici	an	Decedent's Name (First, Middle, Last)							Date of De Month	Day	Year	3. Time of De	eath M
	/Medic		Maryanna S							arch	26,	2006 ounty of Death	1:30P	
	Examin	er	4a. Facility Name (If not institution, give st					Location o						
			1520 Ruston Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. Is	ast hirthday			Heig If Under	7 7 -	. Date of Bir	th	rince (oreion
	Funeral Director			M 2⊠F 51	Yrs.	Months		Hours	Min.	(Month, Da	iy, Year) 2 , 1 95		place (State or Fintry) D.C.	o, o, g, ,
			Usual Residence of Decedent						J.£	eu.	2119.) Wasi	1, 5.0.	
	yland No.		10a. State 10b. County	10c. City	, Town or Lo	ocation							10d. Inside City L	
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	within 72 hours after deeth with the Maryland ene. Than "natural", or itema 23e or 28e-f ahow he Medical Examinar must be notified at		1520 Ruston Avenu	16			2074					ed Stat		
	e de	Funerai	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Deced	dent of Hi cify Cuba	ispanic Orig n, Mexican	gin? (Speci ı, Puerto Ri	fy Yes or No can, etc.)	- 14	. Race - Amer Black, White		
92	or it	y F.	1 □ Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 🗆 Yes	2 (1 kNo	Specify:			s	pecity: B1	Lack	
ğ	ural LEX	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dece	ident's Usu	al Occup	ation			16b Kind	of Business/la	ndustry	
Υ	n 72 "nai	jete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of wa DO NOT u	rk done d se retired	during most	t of working	,	100. 14.10	. 01 000,000	,,	
7	than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Нс	ousewi	ife				Do	mestic		
0	Hyg Hyg other	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle	, Maiden S	итате)		
<u>a</u>	ld be lental ked ic av	To B	George L. Terry					Maı	rie C	. Dozi	er			
Maryland 21215-0036	shou Ind M mar umat	-	19a. Informant's Name/Relationship (Typ	•								Town, State, Zi		
Σ	alth a		John H. Simpkins						, Cap	itol H		s, MD.	20743	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or itema 23s or 28s-f show any figury or other traumatic avent, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re	20b. P	lace of Disperent	osition (Na matory or o	me of other plac	e)	Da	te	20c. Loca	tion - City or T	own, State	
Ĕ	Peg ment ant: h		4 Donation 5 Other (Specify)	Ft.	Linco	oln Ce	emete	ry Ma				ntwood,		
a	port		21. Signature of Funeral Service License		// 2	2. Name a	nd Addres	ss of Facilit	y Poj	oe Fun 38 Mar	eral 1boro	Homes Pike MD. 20		
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):									
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Вох	death certifical e attending phi od for use as th	M	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		□Ectopic p	reanancy	,			23	ld. Date of deli		
	0 0 0	icia	in the past 12 months? 1 □ Yes 2 ☒ No	4 Pregnant at time of de		Other (s						Month	Day Yea	ar
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Ž	Physic this car	2	1 ☐ Yes 2X No	lospital: 1 Inpatient 2				4 140				Other (Spec	ufy)	
	ding P th. After t funera	i.io	27. Manner of Death 1 ☑ Naturaf 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injur Wor			3d. Describe	now injury	occurred		
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Division	or At	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	treet, lacto	ry, onice			City or To	wn, State)	140111001 01 110	ar route rumbe	,,
	a Hospitel or Attend 24 hours efter death a Funeral Director: A stely filled in by the fi		29a. Certifier 1♥ Certifying Phys	sician: To the best of my kno	wiedne des	th occurre	d at the tir	me, date ar	nd place at	nd due to the	cause(s) a	ind manner as	stated.	
	24 hc Fun stely f	Medicai	(Check only 2 Medical Examination one)	ner: On the basis of examina and manner stated.	tion and/or i	investigatio	n, in my c	pinion, dea	ath occurre	d at the time	, date and	place, and due	to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	1000/		29	c. Licens	e number			29d. Date	signed (Monti	n, Day, Year)	
	⊢ s ⊢ ŏ		1 Change in 1	1 Stanoli	nt		DC10	200			March	29, 20	006	
Δ	12		30, Name and address of person who co	empleted cause of death (Iter	n 23a) (Type	e, Print)	_							
K	- 6		Dennis A. Priebat				W; Wa	ashing	gton,	DC.	20010			
	St	ate	31. Date filed (Month, Day, Year)	Registrar's Signa	ture									
100	Regist	trar	APR 0 3 2006	William 1	- 40									

			1 - For State Registrar	State of Ma	ryland	-	rtment of h		nd Mental Hy		06	1205	54
	_		Hegistrar 1. Decedent's Name (First, Middle, La.	st)			incate or	Death	2. Date of De	Reg. No.		3. Time of I	Death
I	Physici /Medic		Yone James	Sugiyama					March	Day 27	2006	9:48	рм
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, o	or Location of	Death	4c. C	ounty of Death		
			Shady Grove Adver	ntist Hospi	tal_		Rockvi If Under 1 Year	11e	A Hrs. I a a	Mor	ntgomery		
	Funeral Director		5. Social Security Number 6. S 554-14-4218	OXM 2□F	(In yrs. las	st birthday) 7 Yrs.	Months Days	Hours	Min. 8. Date of Bir (Month, Date of Bir 2)	ny, Year) 5, 191		lace (State or stry) shingto	
	TO .		Usual Residence of Decedent							, 1)			
	be filed within 72 hours after death with the Maryland Ital thygiene. d other then "natural, or items 23s or 28s-f show event, the Medical Examiner roust be notified at	7	MD Baltimo			Town or Lo	cation				1	0d. Inside City 1 ☑ Yes	
	the M	Funeral Director	10e. Street and Number	ore	Tows	SON	10f. Zip Code			10a Citize	en of What Cour		
	with 15 or	<u>ā</u>	959 Ellendae Dr.				21286					uy:	
	death	era	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. V			in? (Specify Yes or No Puerto Rican, etc.)		JSA . Race - Americ	an Indian,	
٥	or ite	Fur	1 ☐ Never Married 2 🙀 Married	Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give	1941	L - "	Yes, specify Cub ☐ Yes 2 X No		Puerto Rican, etc.)		Black, White,		
21215-0036	urai',	d by	3 Widowed 4 Divorced	Year or Dates:	1961	L					pecify: Asi		
7	n 72 in 72 in at edice	iete	15. Decedent's Ed (Specify only highest gra	ide completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of	of working	16b. Kind	of Business/Ind	dustry	
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٥	be filed stat Hyg od othe event,	Bec	17. Father's Name (First, Middle, Last,		· · · · · · · · · · · · · · · · · · ·			18. Mother	s Name (First, Middle	, Maiden Si	umame)		
Maryland	should be nd Menta marked umatic ev	To	Toyokichi Sugiya	ma				Kats	u Ikeda				
Jar	2 sho		19a. Informant's Name/Relationship (7				or Rural Route Numb	CIT			
	s 1 and 2 should of Health and Men item 27 ie marke other traumatic		George Sugiyama/So	מס	20b. Plac	620 F	ort Will sition (Name of	iams P	kwy Alexar	dria,	VA 223	04 wn State	
Baltimore,	permit. Pages Depertment of I important: If it any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐		сеп	netery, crem	atory or other pla		/5/06				
	ortan ortan injury		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer		Crem	etion 22	Center	ess of Facility	Murphy FH	Cha	ntilly,	VA	
ñ	Deg min and and and and and and and and and an		1 Took City	Taccuster	7-	45	10 Wilso	n Blyd	. Arlingto	n VA	22203		
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	Physician	3	Immediate Cause (Final disease or condition			4866	dod	Tul	afra		1	Onset and Do	
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	nce of):							
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20	death certifical e attending phy d for use as th	Med	IF FEMALE:										
gog	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal d	eath 3 🗆	Ectopic pregnanc	у		230	d. Date of delive Month	,	ear
o.	0 0 0	by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at ti 9□ Unknown	ime or dea	tn 5∐	Other (specify) _					•	
1	g g g	y Ph	Part II. Other significant conditions of	ontributing to death but	not resulti	ing in the un	derlying cause giv	ven in Part I.	23e. Did t	obacco use	contribute to th	e cause of de	ath?
Hecords,	w requires to been signed should be								10	Yes 2□	No 3□Prob	ably LOr	nknown
ပ္သ		Completed							24a. Was		24b. Were auto	osy findings a	vailable
	The ate h page	Com								ormed? 2♥No	death?	npletion of car	129 01
V Ita	ertific ector,	Be	25. Was case referred to medical examiner?						of Death Check only				
0	Physician: this certific al director,	P	1 Yes 2 No	Hospital:		Outpatient	3□ DOA O#	1er: 4 ☐ Nurs	sing Home 5 Resi)	
		tion	1 Natural 5 Pending	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injui Woo	ryat rk? Yes 2.⊟N	28d. Describe	now injury o	occurred		
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not b	e 28e. Pface of Injur	y - At hom	e, farm, stre			28f. Location (Street and I	Number or Rura	Route Numb	er,
ຣົ	2	Certification:	4 Homicide	building, etc.	(Specify)				City or To	wn, State)			
	e Hospitai 24 hours e Funerai letely filled	edicai	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	nysician: To the best of niner: On the basis of e	my knowle	edge, death	occurred at the til	me, date and	place, and due to the	cause(s) ar	nd manner as st	ated.	
	To the h within 24 To the F	Medi	one;	and manner state	ed.		29c. Licens						
	5 ¥ 5 9		29b. Signature and title of certifier	man o	vp.				7455.		signed (Month,)		6
n	(20)		30. Name and address of person who	completed cause of de-	ath (Item 2	3a) (Type 1			. (0)	,,	-1 07	1	
1	100		Dr. Saxena, Sunil					ockvi1	le, MD 208	350			
	Sta		31. Date filed (Month, Day, Year)	2. Registrar			ø.						
	Registr	ar	APR 0 3 2006	Blow	15	Assa	v						

CPM06-02250 Andrew Sewell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a-b.27,28a-f.pen/E.0854,4/20/06 TT State of Maryland Department of Health and Mental Hygiene () ()

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** Olay Andrew Sewell 2ď06 11:40 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1940 Roschelle Avenue District Heights Prince George's | Months | Days | Hours | Min. | 8. Date of Birth | 9. Birthplace (State or Foreign Worth) Day, 1949 | 9. Birthplace (State or Foreign Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 56 579-66-4351 1**/2**M 2□ F Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at D.C. Director Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5339 Ames Street, N.E. 20019 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 2 10 If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic B.F. Goodrich (Retired) other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Washington Cecelia Rozier 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystala Lewis-Sewell (Daughter) 5339 Ames Street, N.E. Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. April 8, 2006 Harmony Memorial Park Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Hom,e 4339 Hunt Place, N.E. Washington, D.C. 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute hepatic necrosis /Medical Due to (or as a consequence of): Examiner Acetaminophen intoxication if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an this certificate hes autopsy 12 Yes 2 🗆 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE Certification: To 1XXYes 2 □ No nours after death.

nerel Director: After this
rilled in by the funeral d 28a. Date of Injury (Month, Day Year) Fnd 4/1/2006 27. Manner of Death 28b. Time of 28d. Describe how injury occurred а 5 Pending investigation 1 Natural Fnd 11:25 M 1 ☐ Yes 2 🗓 No 2 Accident unk 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 1940Roschelle Ave. District Heights, MD 4 Homicide Fnd residence within 24 hours a
To the Funerel C
completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ę 29b. Signature and till of c 29c. License number 29d. Date signed (Month, Day, Year) April 02, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOGAN S.R. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 1 0 2006

Sparke

			. For	State of Marylan		nt of Health and	•	
_			1 - State Registrar		Certifica	te of Death	Reg. No	000 12000
	Physici /Medic		1. Decedent's Name (First, Middle, Last Doris	. Smit	h		2. Date of Death Month Day	Year 7:59 M
16 m	Examin		4a. Facility Name (If not institution, give		1 1 4	y, Town, or Location of Dea	th 4c.	County of Death
	Funeral	2	5. Social Security Number 6. Second	7. Age (In vrs.	(ast birthday) If Und	er 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthplace (State or Foreign Country)
*	Director	:	Usual Residence of Decedent	□M 2XF	Yrs. Month	S Days Hours Min		124 Wash DC
	or death with the Marylan tems 23e or 28e-f ehow at meat be notified at	ctor	10a. State 10b. County		y, Town or Location ashingt	on DC		10d. Inside City Limits 1 ★ es 2 □ No
	with th	Director	10e. Street and Number		10 f. 2	2002		izen of What Country?
	ier death Items 23	Funeral	2545 - 254	h. St. S.(edent of Hispanic Origin? (Secfly Cuban, Mexican, Puer		15 A. 14. Race - American Indian,
21215-0036	hours after death with the Maryland turel; or Items 23s or 28s-f ehow al Evanitrat intest by ricilitied at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 Tyes, sp		rto Rican, etc.)	Black, White, etc. Specify: Black
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212	within liene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Nurs			spital.
	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last)				me (First, Middle, Maiden	Surname)
Maryland	Men Men mrke	To		wie.		Alb	erta T	aylor.
Mar	id 2 sho		19a. Informant's Name/Relationship (T) Vancse Haw	/		ss (Street and Number or R		r Town, State, Zip Gode) 20700 Greenbelt MD
re,	es 1 and of Heatt		20a. Method of Disposition	20b. P	lace of Disposition (Nematery, crematory of	ame of		ocation - City or Town, State
Baltimore,			1 ☐ Burial 2 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		verdale.	Park 3/3	31/2006 R	verdale MD.
Ball	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens	mille	22. Name	And Address of Facility N 7. RHIN	ES FUNER	CAL HOME JASH DC 20017
			23a. Paril. Enter the disease, or compl shock, or heart failure. List only of	ications that caused the death ne cause on each line.	n. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	s <u>S'e</u>	ptic	Shock		Onset and Death
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Вох	ath ce attendi for use	Physician/Med	23b. Was decedent pregnant 2	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	death 3 ☐ Ectopic			23d. Date of delivery Month Day Year
P.0.	that the de ned by the a detached t	yslc	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath 5 Cother (specify)		
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Pi	Part II. Other significant conditions con	ntributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacco u	ise contribute to the cause of death?
Division of Vital Records,	w require been signation						1 ☐ Yes 2 [□No 3□Probably 4 Winknown
3ec	e law has b je 2 st	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
a		မ င်	25. Was case referred to medical	432 - SAVADO		00 8144 419	1 ☐ Yes 2 Z No	1 Yes 2 No
Ž	ysician: us certific director,	0 8	examiner?	lospital: 1 npatient 2 🗆	ER/Outpatient 3□ E	Oth	ath Check only one. Home 5 Residence 6	S ∏Other (Specify)
0 0	ding Ph h. After thi funeral	on: T	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury	
Sio	Attending Physician: r deeth. ector: After this certifici by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not be	CO. Diversitation takes	M	1 ☐ Yes 2 ☐ No	001	
Div	i Bir o	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)		City or Town, State,	
	To the Hospital or Attent within 24 hours after deet To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifier Physical Check only 2 Medical Examinates	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurry ion and/or investigation	d at the time, date and place n, in my opinion, death occu	e and dua to the rause(s) urred at the time, date and	place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			Oc. License number		e signed (Month, Day, Year)
0	(2)		30. Name and address of person who co	empleted cause of death (Item		0006010	ŀ	
_	-6		TALMINA K	AltmED, M	D 300	Hospita	Dr. Che	20785. everly MD.
	Sta Registr		31. Date filed (Month, Day, Year) MAD 2 1 2005	2. Registrar's Signal	ture Acade a			

The law requires that the death certificate ba exacuted Division of Vital Records, P.O. Box 68760.

filad within 72 hours after death with the Maryland

TO PHYSICIAN Maryland 2121

KNOWN TO altimore, I

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 3 1 2006

Thomas Biondo, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VA Maryland Healthcare System, Perry Point, MD 21902

	Dweeney		- State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of F	lealth and Death	Mental	Hygiene Reg. No		120	58
	Physici	an	1. Decedent's Name (First, Middle, Last) JOYCE LOUISE SW	155N/S//				2. Date of Month		y Year 2006	3. Time of I	
16	/Medic	al	4a. Facility Name (If not institution, give s.			4b. City, Town, o	r Location of Dec	Marc		5, 2006 County of Dea		M
	Examin	er	Doctors Community			Lanh		201			George's	ł
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days				9. Bir	thplace (State or	
	Director		577-64-4533 1□ Usual Residence of Decedent	M 201F 67	Yrs.			NOV.	18,19	944WAS	HINGTON	_DC_
	yland Now		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside Cit	y Limits
	e Mar	ctor	MD PRINCE GE	EORGES HYA	77 <i>SVI</i>	ZLLE					1 ∑ Yes	2 🗆 No
	or 28	Director	10e. Street and Number	26.42		10f. Zip Code				tizen of What C	ountry?	
	eath v	by Funerai	7733 RIVERDALE /	ベ <i>UHD</i> I2. Was Decedent Ever in U.5	5 13	20784	ispanic Origin?	Specify Yes o	USA	14. Race - Am	arican Indian	
ထ	or iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐Yes 2 171 No		Was Decedent of H		rto Rican, etc.	.)	Black, Whi	te, etc.	
99	ural', c		3 ☐ Widowed 4 🏚 Divorced	If Yes, Give 'Year or Dates:		1 □ Yes 2/□ No	Specify:			Specify: B.L.	ACK	
15-	within 72 hours after death with the Maryland ene. then 'natural', or items 23e or 28e-f ehow fra Madical Exertirer resal be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking	16b. K	and of Business	/Industry	
212	jene.	omp	Elementary/Secondary (0-12) 117H GRADE	College (1-4or 5+)		TAKER	•		GR	OVNER	HEALTH	CENTI
ם	al Hyg	Be C	17. Father's Name (First, Middle, Last) JOSEPH HARRIS S	C D			18. Mother's Na		ddle, Maider	Sumame)		
yla	ould to	O_					LORRAL					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Itam 27 is marked other than "natural", or items 23a or 28a-f ehow with flutry or other traumatic event, the Madical Examination and Approx. 2006.		19a. Informant's Name/Relationship (Type ANNETTE SWEENEY)	oe, Print) / DANGHTER	19b. Mailir	ng Address (Street CAPI70L	and Number or F H & T G H	Rural Route Ni フト RO	umber, City (or Town, State, ΔΡΙΤΟΛ	Zip Code) 20 HETGHT.	743 S MD
	f Heal fram 2 other		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of matory or other place		Date	_	ocation - City or		
Ë	Page nent o ent: If ury or		1 Burial 2 □ Cremation 3 □ Re □ Donation 5 □ Other (Specify)			MEMORIA	1	IL 320	006 L	ANDOVE	R MD	
Baltimore,	permit. Departr Importe eny Inje		21. Signature of Funeral Service License	ie /		. Name and Addre					20019	7
_	⊈ ⊕ a		23a Fart1. Enter the disease, or complic	Meson		UNN&SON.				E WASH.	ING70N Approximate	
	Discount of the second		Shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.							Interval Betw Onset and D	veen .
7	Physician /Medical		disease or condition resulting in death)	RUPTVEED A Due to (or as a consequ	BOOM!	NAL AD	enl A	NEURY	ISM			
	Examiner		Sequentially list conditions.									
Т	be tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):							
	execut n and al-trar	Exan	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):							
8760,	icate be executed physicien and s the burial-transit	dicai [d									
9	ntifica ing ph	Medi	IF FEMALE:		VI				1			
Вох	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar	death 3	Ectopic pregnancy				23d. Date of de Month		ear
o.	y the c	ysic	1 ☐ Yes 2 ☐ No 9 ☑ N nknown	4☐ Pregnant at time of de 9☐ Unknown	aun 5	Other (specify)			-			
٥.	s that pred b e deta	by Pt	Part II. Other significant conditions conf	tributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. [Did tobacco	use contribute to	o the cause of de	eath?
ord.	w require been sig should b								Yes 2	□No 3□P	robabiy 4 🖄	nknown
ecc	lawr nasbe B2sh	Completed						a	Was an autopsy	pnor to	utopsy findings a completion of ca	vailable use of
<u>a</u>	The icete							XX		death?	2 □ No	
₹	rsicial s certif	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	ospital: 1 □ Inpatient 2X I	ER/Outpatien	t 3□ DOA Cth	er: 4 Nursing			6 ☐Other (Spe	north)	
Division of Vital Records,	Attending Physician: r death. sctor: After this certifice by the funeral director.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury				ibe how inju		City)	
Sio	eath. or: Af the fur	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1 🗆	Yes 2 □ No					
Ξ	or At after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	eet, factory, office			on (Street ar Town, State		ural Route Numb	ier,
_	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	ai C	29a. Certifier 1 ☐ Certifying Physi	ician: To the best of my know	vledge, death	n occurred at the time	ne, date and place	e, and due to	the cause(s) and manner a	s stated.	
	n 24 h	ledicai	(Check only 2 Medical Examin one)	er: On the basis of examinat and manner stated.	ion and/or inv	vestigation, in my o	pinion, death occ	curred at the ti	me, date and	d place, and due	e to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	(29c. Licens				te signed (Moni		
			, mex				С.М.Е.		Marc	ch 26, 2	2006	
K	(5)		30. Name and address of person who cor	mpleted cause of death (Item		Print) Penn Str	eet. Bal	timore	. Mary	land 21	L201	
S	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure		,		,			
	Registr	ar	MAR 3 1 2006	Bridge #	door	Es.						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** ALAN WILLIAM SPECHT March 28, 2:35 p 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2012 Rittenhouse Street Hyattsville Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye March 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Year) Days Hours 1 XM 2 ☐ F 61 Yrs. West Virginia Director 1945 219-46-7597 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location , or Itams 23a or 28a-f show the Medical Examiner must be notified at 1∭Yes 2 □No Funeral Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2012 Rittenhouse U.S.A. 20782 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or Ital any injury or other traumatic event 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor High's Dairy 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Lewis Specht Helen Dorman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shirley Specht - Spouse 2012 Rittenhouse Street, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/1/2006 Brentwood, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature Fuperal Servic Cense 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a. Coronary Artery Disease /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed Sleep Apnea Due to (or as a consequence of): Box 68760 Physiclan/Medical Atrial Fibrillation IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4□Pregnant at time of death P.0. the detached 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Hypo Thyroid; Melanoma 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funeral Di 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier an March 31, 2006 D0034722 ddress of person who completed cause of death (Item 23a) (Type, Print) Name and Vicken K. Poochikian, MD 5632 Annapolis Road, #3, Bladensburg, Maryland 20710-2213 31. Date filed (Month, Day, Year) State MAR 3 1 2006 Registrar

			1 - For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	4000 1	2060
	Physici /Medio		Decedent's Name (First, Middle, Last) Euphama Stout		2. Date of Death Month March 29	, Day 2006 Year	3. Time of Death 6:15A. M
	Examin		4a. Fecility Name (If not institution, give street and number) Genesis Elder Care	4b. City, Town, or Location of Death Riverdale (1) If Under 1 Year If Under 24 Hrs.	La Para et Birth	4c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number 451-26-2018 6. Sex 7. Age (In yrs. last birthda) Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept. 28,	1915 Texa	ace (State or Foreign try) 1S
	Maryland	tor	Maryland Prince George's Beltsvil			10	0d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a	al Director	10e. Street and Number 11334 Melclare Drive	10f. Zip Code 20705		. Citizen of What Coun Jnited Stat	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show many injury or other traumatic avant, Ite Madical Exacting must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 \(\) Widowed 4 \(\) Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\) Yes 2 \(\) No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- O Rican, etc.)	14. Race - Americ Black, White, of Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur	Completed by	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) care Provider	king	b. Kind of Business/Inc	
land 2	ild be filed lental Hygi ked othar ilc avant, I	To Be Co	17. Father's Name (First, Middle, Last) Alpha Walker		ne (First, Middle, Ma		
	is 1 and 2 shou of Health and M item 27 Is mar other traumat	-	The state of the s	ling Address (Street and Number or Rui 40th Avenue Hyatt		-	
Baltimore,	Pages 1 arent of Headurit: If item		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition State	The second secon	Date 20	c. Location - City or To	wn, State
Balti	permit. Departm Importates any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Onald V. Borgwardt 400 Powder Mill Ro	Funeral	Home, PA	
8760,	cate be executed / Medical Examiner site burial-transit	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	re Cardiovasa	Jac Di	sease	Interval Between Onset and Death
.O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as I	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
٥.	w requires that the state of th	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death? ably 4 \(\subseteq Unknown
l Records,	The ate h page	Completed	Diabetes Mellitus		24a. Was an autopsy performe	prior to con	osy findings available inpletion of cause of
on of Vital	tanding Physician: The leath. tor: After this certificate the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 2: Accident investigation 28b. Time (Month, Day Year)	ent 3 DOA Other: 4 Hursing Ho	th (Check only one) ome 5 Residence 28d. Describe how	ce 6)
Division	or At fter c	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	Route Number,
	To the Hospital or At within 24 hours after d To the Funaral Diract completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dead on the basis of examination and/or and manner stated.	ith occurred at the time, date and place, investigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	D within	W	29b. Signature and title of certifier Physical Company of the Com	29c License number		Date signed (Month, I	
			30. Name and address of person was completed duse of death (Item 23a) (Type	203 QUEENSSU	my Rd	Hyu Its	ille MD
	Sta Regist		31. Ďate filed (Month, Day, Year) APR 0 3 2006 32 Registrar's Signature	arke			20781

Registrar DHMH 17 Rev 1/2001

State

W. Ilian

31. Date filed (Month, Day, Year)

11701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

T. TANNER CUS

APR 04

035206

Livings In Road, Fort WARNINGTON, Maryland

06-02	2320
Stoll	Paul

Please Type or Print in Black Indelible Ink

l, Paul		State of Maryland / Department of Health and Mental H 1- For State Certificate of Death Registrar		Reg.	No.200	6 12062
Physician	n/	Decedent's Name (First, Middle, Last)	2. Date of Month	1 0	gay Year	3. Time of Death 11:15
dical Examin	er	PAUL AARON STOLL 4a Facility Name (if not institution, give street and number) 17630 Kohlhoss Road 4b. City, Town, or Location of Death Poolesville		4, 2006	4c. County of Montgom	Death
Funeral Director					(MM/DD/YYYY) 1982	9. 8irthplace (State or Foreig Country) LA
death with the Maryland or items 23a or 28a-f show any must the notified at once.	jo	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD MONTGOMERY POOLESVILLE 10e. Street and Number 10f. Zip Code 17439 HUGHES ROAD 20837		10g	. Citizen of Wha	-
5-0036 tele within 72 hours after tygiene tygiene Medical Examiner	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of If Yes 2 No 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) PAUL ALLEN STOLL 19a. Informant's Name/Relationship (Type, Print) PAMELA ROAN LENZ / MOTHER 20a. Method of Disposition PAMELA ROAN LENZ / MOTHER 19b. Mailing Address (Street and Number or PREDERICK CREMATORY 4 Donation 5 Other Specify: 21. Signature of Furreral Service Licensee 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerton of If Yes, specify: 11 Yes 2 No specify: 12 No specify: 13. Was Decedent of Hispanic Origin? (See If Yes, specify Cuban, Mexican, Puerton of Lagrange Completed) 14 Yes 2 No specify: 15. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired) COLLECTIONS 18 Mother's Name PAMELA ROAN LENZ / MOTHER 19b. Mailing Address (Street and Number or other place) FREDERICK CREMATORY 4 20b. Place of Disposition (Name of cemetery, crematory or other place) FREDERICK CREMATORY 4 22. Name and Address of Facility HILTON FUNERAL PO BOX 86 B 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	work done work done we (First, M A RC Rural Rou Date / 8 / 0	iddle, Ma DAN Ite Numb DLES 6 6	White, Specify 6b. Kind of 8usi FINAN iden Surname) er, City or Town VILLE, 20c. Location - C	WHITE iness/Industry CIAL , State, Zip Code) MD 20837 City or Town, State RICK, MD
be executed cian and urial - transit	Physician/Medical Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	nancy	a. Did tob.	23d Date of o Month	delivery Day Year Dute to the cause of death?
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical Certification: To Be Completed by F	25. Was case referred to medical 26.Place of Death (Chec	1 value of the control of the contro	Yes a. Was ar autops, perform Yes 2) 5 Rescribe how the cause in t	2 No 3 24b. W y y ged? Residence 6 ow injury occurre reet and Numbe ate) 17630 11e, MD y y y y ged? ow injury occurre reet and Numbe ate) 1,030 y y y y ged? ow injury occurre reet and Numbe ate) 1,030 y y y y ged and numbe ate, and du du du du du du du du du du	Probably 4 Unknown Vere autopsy findings available into to completion of cause of avaith? Yes 2 No Other: Scene of or Rural Route Number, Cit Kohlhoss Road as started ue to the cause(s) and (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001 OCME 10/2003

State 31 Date filed (Month, Bay, Year)

32. Registrar's Signature
ORIGINAL

06-02373		se Type or Print in I		lione
Smith, Thomas	5tate of Mary	certificate of	Health and Mental Hyg	ZIIIIN IZIIN.
	Registrar	Certificate of		Reg. No. Date of Death 3. Time of Death
Physician Medical Examin				Month Day Year 16:05
Wedical Examin	4a. Facility Name (if not institution, give street and		b. City, Town, or Location of Death	4c. County of Death
()	817 Hill Top Drive	,	Cumberland	Allegany
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MMDD/YYYY) 9. Birthplace (State or Foreign Sept 14, 1925 Country)
Director	213-22-2720 1XM 2	80 Yrs	World's Days Flours Will.	April 6,2006 PA
,	Usual Residence of Decedent	40. Ot Town and another		10d, Inside City Limits
* an	10a. State 10b. County	10c. City, Town or Locati Cumberlar		1 XYes 2 No
land f sho	MD Allegany	Cumberrar		10g. Citizen of What Country?
Mary r 28a- ed at	10e. Street and Number 817 Hilltop Dr.		10f. Zip Code 21502	USA
th the 23a of				
Baltimore, MD 21215-0036 Demit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- II. Maritar Otatar		s Decedent of Hispanic Origin? (Spec es, specify Cuban, Mexican, Puerto Ri	
er dea	1 Ye 3 Widowed 4 Divorced If Yes, Give	s 2 No Year WWII 1	Yes 2x No specify:	Specify: White
rs afte ural"	or Dates:		t's Usual Occupation (Give kind of wor	
2 hour "nate	Elementary/Secondary (0-12) College	during	working life. DO NOT use retired)	
136 hin 7. e. than than	1 2		e Technician	Telephone
5-00 ed wit sygien other Me M	15. Decedent's Education (Specify only highest (Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)	_	18.Mother's Name (F	irst, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Charles L. Smith			. Spicher
1 21 lould I d Met s man	O 19a. Informant's Name/Relationship (Type, Print)		,	ral Route Number, City or Town, State, Zip Code)
MD d 2 sho Ith and Ith and aumat			. Burke St. Ma	rtinsburg, WV 25401 Date 20c. Location - City or Town, State
re, h s and f Healt ff item	20a. Method of Disposition 1 Remove	crematory or ot	ner place)	
MO Page nent o	4 Donation 5 Other Specify:	Sunset N	Memorial Pk Apr	10 06 Cumberland, MD
Baltimore, permit Pages I at Department of Hee Important: If ite	21. Signature of Funeral Service Licensee	22. N	lame and Address of Facility Haf	er Funeral Service, PA
m 22 i i	23a. Part I. Enter the disease, or complications the	13	02 National Hw	y., LaVAle, MD 21502
Physician	23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	at caused the death. Do not enter t	ne mode of dying, such as cardiac or r	Detween Onset and
/Medical Examiner	Immediate Cause (Final disease a. Atheroso	lerotic Cardiovascular Dis	ease	Death
	· ·	as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or a	as a consequence of):		
	S cause. Enter Underlying Cause	20 4 001100 4401100 01/1		
,=	(Disease or injury that initiated events resulting in death) Last Due to (or a	as a consequence of):		
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oe exe irial -	Σ UNPENDED XX AMENDE	□Amend #8 Per	Inf G856 6/16	/06 JH
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ords, w requir s been s should!	etec			24a. Was an autopsy findings available prior to completion of cause of
COF law r has b	าดีน			performed? death?
Re(The ficate	Completed		00 Pl	1 ✓ Yes 2 No 1 ✓ Yes 2 No
ital Recician: The last certificate h	25. Was case referred to medical examiner? Hospital: 1	□	26.Place of Death (Check or	Home 5 Residence 6 ✔ Other Scene
FVit Physic rthis al din	Yes 2 No	Inpatient 2 ER/Outpatien ate of Injury 28b. Time of		28d. Describe how injury occurred
n of V ding Ph	27. Manner of Death 1 V Natural 5 Pending	ate of Injury 28b. Time of lonth, Day, Year)	1 Yes 2 No	See Best Be now injury decemen
SiOI Vittene death death	2 Accident Investigation	Non of Inium. At home force store		28f. Location (Street and Number or Rural Route Number, City
Division of Vital Records, rat or Attending Physician: The law requir is after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Suicide 6 Could not be	Place of Injury - At home, farm, stre	et, ractory, ornce building, etc.	or Town, State)
id or pi			and at the state of the second state of the second	huo to the equipo(e) and manage as alest
To the Hos within 24 h To the Fun	(Check only one) 2 Medical Examiner: On the ba	best of my knowledge, death occurs is of examination and/or investigation	rred at the time, date and place, and d ation, in my opinion, death occurred at	fue to the cause(s) and manner as started. the time, date and place, and due to the cause(s)
To tl withi Comp	and manr		29c. License number	29d Date signed (Month, Day, Year)
	29b. Signature and title of certifier		200 Elocipo Hambor	A ::: 1.7 . 0000

April 7, 2006

1211

State Registrar

30 Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

ORIGINAL

O.C.M.E.

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Gertrude Marie STOUFFER /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year If Under 24 Hrs. B. Date of Birth Months Days Hours Min. Feb. 25,1916 Funeral 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F 90 Yrs. 220-16-1815 **Director** Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Public notified at Directo Maryland Washington 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 W. Wilson Blvd. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: other traumatic event, the Medical Exam δ Specify 3 XWidowed 4 ☐ Divorced white natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker 0 her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental h Be Chester A. Long Ethel Mae Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 117 Sunbrook Lane, Hagerstown, Maryland 21742 Jean M. Taylor - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō `4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 4/4/06 Hagerstown, Maryland 24 Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Conges Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medicai attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? rector, page 2 s 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No of Vital 1 Yes 2 No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ို 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04/0 NO 60396 3106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) orgi

Registrar DHMH 17 Rev 1/2001

State

FARID 31. Date filed (Month, Day, Year)

APR 03

2006

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MUNSHED

32. Pegistrar's Signature

			Please	Type or Print in E						_	
			For State Registrar	State of Marylan		artment of H <i>rtificate of L</i>		lental Hy	ygiene Reg. No	2000	12065
	Dhysia		1. Decedent's Name (First, Middle, La	st)				2. Date of D	eath Da	y Year	3. Time of Death
	Physic: /Medi		BETTY LORRAINE	STOUFFER		,		March	1 3		00:30 M
	Examir	er	4a. Facility Name (If not institution, giv				Location of Death		40	. County of Death	
			WASHINGTON COUNTY				GERSTOWN			WASHING	
	Funeral Director		5. Social Security Number 6. S 214-28-0257 Usual Residence of Decedent	6ex 7. Age (In yrs. i	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	irth Pay, Year) L8 , 1		elece (State or Foreign etry) RYLAND
	land ow		10a. State 10b. County	10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	the Mary 28a-1 eh	Funeral Director	MARYLAND WASHII	NGTON		BOON:	SBORO		10g Ci	tizen of What Cour	1 □Yes 2 No
	with 3a or	ō		DOAD			71.0		109.01		lly!
	Jeath ne 23	era	21363 MOUNT LENA	12. Was Decedent Ever in U.	S. 13.		713 spanic Origin? (Spe	ecify Yes or N	0-	U.S.A.	an Indian
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 le marked other then "natural", or iteme 23a or 28a-1 show other traumatic event, the Mudical Experient must be notified at	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, White,	
ŏ	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. K	and of Business/Inc	
215	within 7 ene. then "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	luring most of worki)	ng			,
2	iled with tygiene. her the	Con	12			CASHIER				ELECTRIC	COMPANY
p	d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Name				
yla	Men Men arke	မ	HERMAN DAVID SHAN	VK			FRANCES	LILLIA	N BO	STETTER	
Maryland	2 shot and and le m		19a. Informant's Name/Relationship (1	ng Address (Street a					Code)
-	l and lealth im 27 her t		FAYETTE W. STOUFI 20a. Method of Disposition			3 MT. LEN		-	-		21713
Baltimore	0 0		1 Burial 2 Cremation 3 4 Conation 5 Other (900)	Removal from State	emetery, crei	osition (Name of matory or other place RG CREMAT(9)	1/06	i	ocation - City or To	MARYLAND
Balt	permit. Pag Deportment Important: I any injury o		21. Signature of University Sporice Light	Paul M. De	an B	2. Name and Addres	s of Facility AL HOME	7606 O. Boosnbe	ld Na	ational F Maryland	ike
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac c	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cordio	-Ves	Diret	ry F	a, lu	10		Onset and Death
7	/Medical Examiner		resulting in death)	Due to for as a consequ	- 4						
	Examiner		Sequentially list conditions.	b. Sepsis	in	The All	elomin	al A	ters	Cers 1	ever alla
	si ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	ience of):		λ	0-	4-	clip lysis.	
	and I-trans	Kam	that initiated events resulting in death) Last	c. Due to (or as a consequ	ge	Kenal	Diseas.	e ont	7emo	elalysis.	Several to
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687	physicate the later	dlc	•	d.	1 ev	LIVA	1200	TV1S	254	the J	werd Yr
Вох	The law requires that the death centificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of delive Month	ry Day Year
P.O.	that t	H.	Part II. Dther significant conditions of	ontributing to death but not resu	Iting in the u	nderlying cause give	n in Part I.	23e, Did	tobacco	use contribute to th	e cause of death?
gp	w requires that s been signed t should be deta	d by	Perfor	ation of C	olo	حم			,		ably 4 □Unknown
Ö	v req	ete	Isalia	. 10	1:1						
Records,	The law	Completed	1	CAIL O	D	3	- 1	24a. Was		prior to condeath?	osy findings available npletion of cause of
ā		ပိ	25. Was case referred to medical	ria Pi	eleno	nary 18	=darma	1 ☐ Yes	2 25 No		2 No
of Vital	Physiclan: r this certifica ral director, I	00	examiner? 1 \(\subseteq \text{Yes} \text{2No} \)	Hospital:		othe Othe	26. Place of Death				
ō	Phys er this eral di	7: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of	I 3 DOA	4 Indising nor	ne 5∐ Res 28d. Describe		6 □Other (Specify v occurred)
ion	Attending I or death. ector: After by the funer	at lo	1 Natural 5 Pending 2 Accident investigation		Injury		? 'es 2 ☐ No				
Division	I or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	2	28f. Location (City or To	(Street ar	nd Number or Rura	Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific complately filled in by the funeral director.	edical Co	(Check only 2/ Medical Exam	ysician: To the best of my knowniner: On the basis of examinat	wledge, death	n occurred at the tim	e, date and place, a	and due to the	cause(s)	and manner as st	ated.
	thin 2 the mplat	Med	(ine)	and manner stated.							
	Z Y Z		29b. Signature and title of certifier	and		29c. License				te signed (Month, L	
						1033	5497		2	31.06	>

State Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

TANVIR A MSHA MD 1122 OPAL CT. HAGERS TO COP, MD 2174 31. Date filed (Month, Day, Year) APR U 3 2006

32. Registrar's Signature

		1 - For State Registrar	State of	Marylan	•	artment of rtificate of	Health and <i>Death</i>	Mental H	ygiene Reg. No. () (16	12066
Physic /Medi		Decedent's Name (First, Middle, La MARY ELLEN SHA		·				2. Date of D Month March	Dav	2006	3. Time of Death 7:08 PM
Examir		4a. Facility Name (If not institution, given 11512 Ashley Dri		ber)			or Location of Dea		4c. Count Mont	y of Death gomer	
Funeral Director		5. Social Security Number	Gex 7 1 □ M 2 🂢 F	7. Age (In yrs. 65	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of B	30,1940	9. Birthr Cari Wash	place (State or Foreignity) Lington D.(
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
Maryl I eho	tor	Md. Montgom	ery	1	ockvil						1 ☐ Yes 2 🛣 No
th with the 23a or 28a	Funeral Director	10e. Street and Number 11512 Ashley Dri	ve			10f. Zip Code	20852		10g. Citizen of United		•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show man important: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show man once.		11. Marital Status 1 Never Married 2 Married 3 MWidowed 4 Divorced	12. Was Deced Armed Ford 1 Yes : If Yes, Give Year or Da	ces? 2 ANo		Was Decedent of If Yes, specify Cui 1 ☐ Yes 2 🕅 No	Hispanic Origin? (can, Mexican, Pue Specify:	(Specify Yes or Nerto Rican, etc.)	Bla	ce - Americ ck, White, fy: Whi	
72 hc	etec	15. Decedent's E (Specify only highest gr		_	16a. Dece (Give	dent's Usual Occu	pation during most of w	rorking	16b. Kind of B	Business/In	dustry
within then then	Completed by	Elementary/Secondary (0-12)	College (1-	4or 5+)		ch Manag			Banki	ng	
id be filed lental Hyg 'ked other Ilc event,	To Be C	17. Father's Name (First, Middle, Last Louis Harrison R	•					ame (First, Middl helma Wi	ile, Maiden Sumar illett	me)	·
and 2 should and No. 27 le mail		19a. Informant's Name/Relationship (William Austin Sh	• .	(Son)					ber, City or Town 1d • 20720		Code)
Pages 1 ment of He ent: If Iten ury or oth		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		tate	se Hil	osition (Name of matory or other place) 1 Cemete	ry 20	ril 4, 006	clear,	Sprin	
permit. Depertm Importe any Inju		21. Signature of Funeral Service Lice	bey		1	0 East D	eer Park	Dr. Gai	neral Hon thersbur		d. 20877
Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Arter Due to (c	ioscle	rotic I	erthe mode of dy		ac or respiratory	arrest,		Approximate Interval Between Onset and Death
cate be executed physicien and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseq							
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours effer death. To the Funers! Director: Affer this certificete has been signed by the ettending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (∑No 9 □ Unknown		nth 2 ☐ Feta unt at time of c	al death 3	Ectopic pregnan Other (specify)	cy			ate of delive	ery Day Year
quires that n signed b	þ	Part II. Other significant conditions Hypertension	contributing to de	ath but not res	sulting in the u	nderlying cause g	ven in Part I.		tobacco use con Yes 2 ☑ No		he cause of death?
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To the Hospital or At within 24 hours efter of To the Funersi Direct completely filled in by	O	29a. Certifier 1 🕅 Certifying P	hysician: To the	g, etc. (Special	owledge, deat	h occurred at the	time, date and pla	ce and due to the	e cause(s) and m	anner as s	stated
o the Ho vithin 24 I o the Fu ompletely	Medical	(Check only one) 2 Medical Exa	miner: On the ba	sis of examina	ation and/or in	vestigation, in my	opinion, death oc	curred at the time	e, date and place,	and due to	o the cause(s)
ĕ → ₹ →		▶ Wilhelm	ma g.		1		21662		_	4	31/004
10		30. Name and address of person who Dr. Wilhelmina G					Street	Rockvill	le, Md.	20853	
St Regist	ate rar	31. Date filed (Month, Day, Year)	2000	distrar's Signa	ature	forth				· · · · · · · · · · · · · · · · · · ·	
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DHMH 17 Rev 1/2001

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			For State			d / Depa	artment of h	Health a	and Menta	l Hygi		06	1200	57
			Registrar 1. Decedent's Name (First, Middle, L.	ast)			Timodio or	<u> </u>		e of Death	1		3. Time of I	Death
	Physici	an		Charles I	Chomas.	.Ir.			Mor MAR	nth	Day 25	2006	5:06A	
	/Medic		4a. Facility Name (If not institution, gi				4b. City, Town, o	or Location		CII		ounty of Death		•
1	Examin	er		ve street and num	Der)		HYATTS		or Death			NCE GE		
			5405 35th Ave 5. Social Security Number 6.	Sex 7	7. Age (In yrs.	last hirthday			24 Hrs. 8 Date	e of Birth	1			Foreign
	Funeral Director		219-25-4759	18 M 2 □ F	31		Months Days	Hours	Min. (Mo.	of Birth	Year)	75 Was	nplace (State or untry) shingtor	ת מושות
		ŀ	Usual Residence of Decedent						rial	JII 10	, I.	//J Was	mingcor	1, 10.
	/land		10a. State 10b. County			y, Town or L							10d. Inside City	y Limits
	Many -feh	Ö	Maryland Prince	George	Ну	attsvi	ille						tX□ Yes	2 🗌 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 le marked other then "naturel", or Items 23a or 28e-f ehow any Injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 5405 35th Aven	ue			10f. Zip Code 20782			10	-	n of What Co	•	
	death	Jere	11. Marital Status	12. Was Deced		.S. 13.	Was Decedent of I	Hispanic Or	igin? (Specify Ye	s or No-	14	. Race - Ame		
(0	ifer and a second	교	1 ☑ Never Married 2 ☐ Married	Armed For	2 🔀 No					etc.)		Black, White pacify: B1		
93	ers a	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	e tes:		1 ☐ Yes 2X No	Specify:			S	pecify: DI	ack	
9	2 ho	Completed	15. Decedent's I	Education		16a. Dece	dent's Usual Occu	pation	t of working	1	6b. Kind	of Business/I	ndustry	
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2	od wii	5	12th			Mai	Intenance					ivate		
p	at Hy foth	Be (17. Father's Name (First, Middle, Las	•					er's Name (First,			umame)		
<u> a</u>	Venti Venti rked	10	Albert C. Thom	as, Sr.				Shi	rley J.	Smit	h			
Maryland 21215-0036	and l		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street	and Numb	er or Rural Route	Number,	City or	Town, State, Z	ip Code)	
	and alth		Shirley J. Thom	as/Mother	r	5405	35th Ave	., Hy	attsvill	e, M	d.	20782		
re	of He		20a. Method of Disposition	□ D 14 0	,	Place of Disperentery, cre	osition (Name of matory or other pla	ice)	Date	2	Oc. Loca	ation - City or	Town, State	
Ĕ	Page lent c nt: If		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Met	ropoli	tan Crem	atory A	pril 3, 2	2006	Ale:	xandria	a, VA.	
Baltimore,	permit. Departm Importa any Inju		21. Signature of Funeral Service Lice	ensee	foll	Po	2. Name and Address Ope Funer Orestvill	al Ho	mes; 553	8 Ma	r1bo	ro Pik	e	
	_		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that ca	used the deat	h. Do not en	ter the mode of dy	ng, such as	cardiac or respir	atory arre	st,		Approximate Interval Betw	,
760,	that the death certificate be executed Examined by the attending physicien and detached for use as the burial-transit	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. — Doe to (c	or as a consequence as a consequence or a consequence or a conseque	uence of): (uence of).	s TO (MEST	AND A	800	ME	N	Onset and D	
89	certificat nding phy use as th	edi						_						
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Division of Vital Records, P.	w requires that the death's been signed by the atter's should be detached for u	d by Pi	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the t	underlying cause gi	ven in Part I	. 23	e. Did toba	_		the cause of de obably 4 ⊡U	
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Re	ba:	E								autopsy perform	ed?	death?	completion of ca	use of
a	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					oe Blee		-	□ No	Yes	2 No	
Ξ		00	examiner?	Hospital:	npatient 2	1 CD/Outpatio	nt 3 DOA Ct		e of Death <i>Ch</i> ecursing Home 5			Mother (See	SCENE	
of	Phys r this ral di	2	27. Manner of Death	28a. Date o	f Injury	28b. Time o				scribe ho			,ny/ DOLLIAL	
on	nding th. : After e funer	ţ	1 □Natural 5 □ Pending 2 □ Accident investigati		n, Day Year)	4:49		ork?]Yes 2,∭K	No SVE	STECT	T W	2 2A	HOT	
Si	deal deal ctor: y the	lica	3 Suicide 6 Could not	be 28e, Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Loc	ation (Str	eet and	Number or Ru	ral Route Numb	ber,
<u>S</u>	after Dire	Certification:	4 Homicide	buildin	ig, etc. (Special SSIDE)	fy)	,,		540	y or Town,	, State)	E HYA	TISVILL	E.HD
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	(Check only 27 Medical Ex	Physician: To the aminer: On the ba	best of my kno	owledge, dea			nd place, and due	to the ca	use(s) a	nd manner as	stated.	
	the Jin 2 the I	led	one) A	and mann	er stated.		20. 1:			1.00	N. D.A.	-i	Day Varal	
	S with S	-	29b. Signature and title of certifier					se number				signed (Montl		
	7		, met	<u> </u>			0.0	.M.E.		M	ARCH	25, 20	JU6	
	(2)		30. Name and address of person wh	310 , M	W		111 PENN	STRE	ET BALTI	MORE	, MA	RYLAND	21201	
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 3 200	6 Sec. 12. Re	egistrar's Signa	atūrė	le							

			1 - For State Registrar	State of M		epartme <i>Certifica</i>			nd Mental Hy	giene	6	120	68
	4 7 -		1. Decedent's Name (First, Middle, Las	1)					2. Date of De			3. Time o	of Death
Н	Physici		Bernice		Thayer				March	25 ^{Day} 20	0^{Year}	6:35	Ам
	/Medic Examin	.0	4a. Facility Name (If not institution, give	street and number)		4b. Ci	ity, Town, or	Location of	Death	4c. County	of Death		
			Southern Marylan	d Hospita	.1		Clint	on		Princ	e Geo	orges	
	Funeral		Social Security Number 6. S		je (In yrs. last birt	hday) If Und Month	der 1 Year	If Under 24 Hours	4 Hrs. 8. Date of Bi	th v Year)	9. Birthp	lace (State	or Foreign
Ш	Director		227-32-3990	□M 2 ⊠ F	6 6	Yrs.	ls Duys	110013	October	1,1939	Sout	h' Car	olina
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					1	Od. Inside (Tity Limits
	•ho	ō	MD Prince G	enroes		r Marl	boro				'		s 2 🗆 No
	28a-f	ect	10e. Street and Number		OPPC		Zip Code			10g. Citizen of V	What Cour		
	with	<u>ā</u>	5701 Federal Cou	rt		101.	2077	2		USA	What Cour	itiy:	
	within 72 hours after death with the Maryland ene. then "netural", or itema 23e or 28e-f ehow fre Medical Exercitres must be rollified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of Hi	spanic Origi	n? (Specify Yes or No		e - Americ	an Indian.	
,	r Iten	ᆵ	1 ☐ Never Married 2 ☐ Married	Armed Forces	•	If Yes, s	pecify Cuba	n, Mexican,	Puerto Rican, etc.)	Blac	k, White.	etc.	
93	urs a	þ	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 🔼 No	Specify:		Specify	Blac	:K	
Ō	2 ho	Completed	15. Decedent's Ed	ucation	16a.	Decedent's U	sual Occupa	ition	-	16b. Kind of Bu	isiness/ind	dustry	
21	thin 7	ple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	(Give kind of life. DO NO)	Fuse retired,)	or working	Priv	ate		
21	ad wi	S		4yrs	En	trepre	neur		****				
nd	tal Hy doth	Be	17. Father's Name (First, Middle, Last)						s Name (First, Middle		e)		
χ	Men Merke arke	ို	,	ouse				Berni		Dowell			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or itema 23s or 28s-f ehow warb flurry or other traumatic event, the Medical Examinar must be notified at Angle.	0 3	19a. Informant's Name/Relationship (7) Bennice Thayer-Blo						or Rural Route Numb Upper Ma:			Code)	
-	Heall Heall tem 2		20a. Method of Disposition	une, baugn	20b. Place of	Disposition (A	Vame of			20c. Location -			-
altimore,	ages ant of t: If if		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Resurr	y, crematory o ection			04/0172006	Clinto	-		nd
Ħ	artme ortan Injuri	. 1	21. Signature of Funeral Service Licens		2			٠,	J.B. Jenk		-		
Ba	Pern Dep Imp		K. N. Wa	-hall	7				l., Landov		20785		
	36		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	d the death. Do n	not enter the m	node of dying	g, such as ca	ardiac or respiratory a	rrest,		Approxima	ate
	Physician		Immediate Cause (Final	. Awt		CARDI						Onset and	
ě,	/Medical		disease or condition resulting in death)	ч	a consequence of		HE IN	JAMEC	17010				
32.	Examiner		Commented to Control of the	b									
	D =	ner	Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying		a consequence o	of).							
	nd	am	that initiated events	C.									
Ö,	ian a	Ë	resulting in death) Last	Due to (or as	a consequence of	of):							
8760,	cate be executed physician and the burial-transit	dical Examiner		d							-		
9	entific fing p	Me	IF FEMALE:	00- 4									
Bo	ath c attend for us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death					23d. Dat Mor	e of delive nth	Day	Year
O	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant a 9□Unknown	t time of death	5 Other	(specify)						
Division of Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending I bage 2 should be detached for use as		Part II. Other significant conditions co	ntributing to death b	out not resulting in	the undertying	a cause dive	n in Part I.	23e. Did	obacco use contr	ribute to th	ne cause of	death?
ds,	sign d be	d by	HYPERTENSION		3		y y					ably 4X	
ö	w requir been si should	Completed	END STAGE REM		14 7					045.1			(-61.
36	has has ge 2 :	ďμ	END 21405 KEN	10 200	NE				24a. Was	osy p	vere autop prior to cor leath?	psy findings npletion of	cause of
a	tician: Th certificate rector, pag		1						1 ☐ Yes		Yes	2 🗌 No	
Ĕ	siciar certif	Be	25. Was case referred to medical examiner?	Hospital:	-/		DOA Othe	r	f Death Check only		-		
ō	Phys this ral di	. To	1 ☐ Yes 2 🖾 No 27. Manner of Death	1 ☐ Inpati			DOA	4 Nuis	ing Home 5 Reside	dence 6 Other		1)	
0	ding h. After funer	ti P	1 ☑Natural 5 ☐ Pending	(Month, Da		njury M	28c. Injury Work	? ′es 2 ⊡No		now injury occurr	90		
2	Attending Physician: or death. ector: After this certifice by the funeral director. E	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	ury - At home, far					Street and Number	er or Rura	I Route Nu	mher
<u>S</u>	after Dire	Certification:	4 Homicide determined	building, e	c. (Specity)		.,,		City or To	wn, State)			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge	, death occurre	ed at the tim	e, date and	place, and due to the	cause(s) and ma	nner as st	ated.	
	n 24 he Fu	edical	(Check only 2 Medical Exam	iner: On the basis of and manner st	if examination and	Vor investigati	on, in my op	inion, death	occurred at the time,	date and place, a	and due to	the cause	(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			2	29c. License			29d. Date signed			
•	(10000	,			D 40	324		MARCH 2	512	006	
0	(6)		30. Name and address of person who c	ompleted cause of	leath (Item 23a) (Type, Print)		-d) .			7		
			TERRY DORIE,				LOAD,	CLIN	TON, MAR.	1LAND	1073	35	
	Sta Registr		31. Date filed (Month, Day, Year)	1	ar's Signature	Conti							

LLC.	00		1 - For State Registra MEND#27, 28	State o	f Marylan	d / Depa	artment of H	ealth and		7 HUb	120	69
			Hegistrari LLNDHZ / , 20 Decedent's Name (First, Middle)	e. Last)	יי, אויים, סטקנ	10000	uncate of L	Jeani	2. Date of Dea	Reg. No.	3. Time o	f Death
	Physicia		M	ANIVONE	тинт	ONESIE	т		Month MARCH	Day Year		A M
1	/Medic Examin		4a. Facility Name (If not institution			ONLDII	4b. City, Town, or	Location of Dear		26, 2006 4c. County of Dea	0510_ th	_A
			1408 HAMPSHIRE	WEST CT.			SILVER SI	PRING		MONTGOM	ERY	
	Funeral Director		5. Social Security Number 212-49-6999	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. 31	Ven	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	y, Year) 9. Bir	thplace (State ountry)	or Foreign
			Usual Residence of Decedent		<u> </u>				AFKIL	14,19/4	LAOS	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. tnside C	•
	8a-1	Director		IGOMERY			SILVER SI	PRING			21	2 🗆 No
	with th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?	
	eath	erai	1408 HAMPS		CT. edent Ever in U.	c 12.1	209		Pagain Van er No	LAOTIA		
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Heelih end Mental Hygiene. Deperment of Heelih and Mental Hygiene. If them 27 is marked other than "naturel", or theme 23a or 28a-f show eny highly or other traumatic event, the Medical Examination and the notified at once.	by Funeral	1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Formed 1 Tyes	orces? 2∏XNo ve		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 \$\frac{1}{2}\$ No	Specify:	to Rican, etc.)	Specific		
21215-0036	2 hou	Completed		t's Education		16a. Dece	dent's Usual Occupa	tion		16b. Kind of Business		
215	thin 7	ple	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of work done d DO NOT use retired;	uring most of wo	orking			
21	ygien ygien t, t	Co	12		·	PAC	CKING WORK			CHICKEN PO	ULTRY C	0
Maryiand	be fill d off	Be	17. Father's Name (First, Middle, UNK •	Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	UNK.	
Ž	hould d Mer marke matic	٦	19a. Informant's Name/Relations	hip /Tuna Print)	THAV	ONESIR		and Aliam bear as D	lucal Davida Aliverta	- C' T C'	7. 0. 1.	
Ma	d 2 si th en t7 is r traur			HOMSAVAT/I	מואים ד מיק	5017				r, City or Town, State, MD • 20710		
ē,	other U		20a. Method of Disposition	HOMSAVAI / I	20b. P	lace of Dispo	sition (Name of		Date	20c. Location - City or		
E O	Pege and of the pege and of th		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		State		CREMATORY	1	2006	RIVERDALE	MD	
Baltimore,	permit. Depertm Importa eny Inju		21. Signature of Funeral Service	Licensee	. 00	22	Name and Addres	s of Facility	HOME & C	REMATORTIM	. Р. А.	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of	aused the deatl	n. Do not ent	er the mode of dying	LAND AV , such as cardia	c or respiratory ar	RDALE, MD.	Approximat	
)	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Mu	CTIPLE (or as a conseq		VSHOT	LOHVON			Interval Bet Onset and	
	De is	Examiner	rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Dise to	(ur as a conseq	uanna of):						
_	xecuti and II-tran	хап	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):						
8760,	icate be executed physicien and the burial-transit	dicai E		4	, , , , , , , , , , , , , , , , , , , ,							
Φ	tificat ig phy as th	ledi		-								
.O. Box	es that the death certifi igned by the attending be detached for use as	by Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	1☐Live t	tcome of pregna pirth 2 Peta nant at time of d own	ldeath 3□	Ectopic pregnancy Other (specify)			23d. Oate of de Month		Year
rds, P	lew requires that the as been signed by th 2 should be detache		Part II. Other significant conditi	ons contributing to d	eath but not res	ulting in the u	nderlying cause give	n in Part I.		ebacco use contribute to	the cause of c	
Vital Record	The ete h	Completed									utopsy findings completion of c	available ause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:			Otho		ath (Check only or			
		. To	1 XYes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time of		4 Nursing I		ence 6_Other (Spe	city) SCENI	3
Division of	Attending Phy r death. actor: After thi by the funeral o	tlor	1 Natural 5 Pendir 2 Accident investi	(Mon	th, Day Year)	5:00	Work	es 2 No				
<u>Visi</u>	Atter r dea ector by the	ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (S	was shot Bireet and Number or R	ural Route Num	nber,
Ö	s efte	Certification:	442 Romode		ing, etc. <i>(Specit</i>) rtment	Y)			1408 Ha	wpshire We Spring, MD	st Cour	rt #3
	To the Hospitel or Attent within 24 hours effer death To the Funerel Director: completely filled in by the	edical (29a. Certifier 1 Certifyii (Check only one) 1 Medical	ng Physician: To the Examiner: On the b	best of my kno	wledge, death tion and/or in-	n occurred at the tim vestigation, in my op	e, date and plac inion, death occ	e, and due to the o	cause(s) and manner as date and place, and due	s stated.	
	To th Withir Comp	Me	29b. Signature and title of certifie	r			29c. License			29d. Date signed (Mont		
	1		> and				OCM	Œ	1	MARCH 27,	2006	
	·		30. Name and address of person ANA RUB	who completed caus	se of death (Item			EET, BAL	TIMORE, 1	MARYLAND, 2	1201	
	Sta Registr		31. Date filed (Month, Day, Year, APR 0 3	2006	Registrar's Signa							

		-	For State Registrar	State of M	aryland /		artment rtificate			and M		giene No.	6	120	70
	Physicia		1. Decedent's Name (First, Middle		MARCHI	•					2. Date of Dea Month APRIL 3	Day	Year	3. Time o	
	/Medic Examin	ai -	VICTOR JOSE 4a. Facility Name (If not institution		ARCHI		4b. City,	Town, or	Location o		AI KLU J	4c. County	of Death		n
			15350 CHRISTY I				IKT In day		DORF If Under	24 Uro	a Data (Bin		HARL		
	Funeral Director		5. Social Security Number 084-20-7607	6. Sex 7. Ag 1 M 2 ☐ F	e (In yrs. last b 78	Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt (Month, Day NOV 2,	Year) 1927	Cor	nplace (State untry) YORK	or Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside C	ity Limits
	Maryl.	tor	MARYLAND CHAR	RLES			WALDO	RF						1 🗌 Yes	2 ∑ No
	or 28s	Oirec	10e. Street and Number				10f. Zip					10g. Citizen of			
	eath w	Funerai Director	15350 CHRISTY I	LANE 12. Was Decedent	Ever in U.S.	13.	Was Deced		601 spanic Ori	igin? (Sp	ecify Yes or No	UNITED		ncan Indian,	
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or itama 23a or 28a-f show simportant: If item 27 is marked other than "healtral", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Evaluation must be notified at once.	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1	lf Yes, spec 1 ☐ Yes		Specify:		ecify Yes or No Rican, etc.)	Specii	rck, White	e, etc. ITE	
15-0036	"natur	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	16	(Give	dent's Usua kind of wor DO NOT us	rk done d	luring mos	t of work	ing	16b. Kind of B	Business/I	Industry	
2121	d within 72 giene. ir than "nal	omo	Elementary/Secondary (0-12)	College (1-4or	5+)			TCHE				U.S.	GOV	ERNMEN'	T
nd	be filed htal Hygie od othar evant, tt	Be	17. Father's Name (First, Middle,								e <i>(First, Middl</i> e, LA CIOP		me)		
Maryland	2 should be and Mental is marked (ို	ROSARIO TRIMARO 19a. Informant's Name/Relations		1:	9b. Maili	ng Address	(Street a			al Route Number		, State, Z	Tip Code)	
	1 and 2 Health ar tem 27 is		ROSARIO V. TRIM	MARCHI - SON					LANE	-	LDORF,				
ore	Pages 1 nent of He ant: If iter ury or oth		20a. Method of Disposition 1 D Burial 2 Cremation		1	tery, cre	osition (Nan matory or o REMATO	ther place	1	APR 3, 2		20c. Location	•		D
Baitimore,	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (S		HONT		2. Name an		_		UNTT FU	WALDOR NERAL H		AXILAN.	D
<u>~</u>	Depa Impo any ii		Mark y. 1	Stoheun	M0005						RF, MAR		2060		
	Pnysician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	t only one cause on each	d the death. Dine.		ter the mod			cardiac	or respiratory a	rrest,		Approxima Interval Be Onset and	etween
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		a consequenc	ce of):									
,092	ate be executed hysician and the burial-transit	ical Exan	that initiated events resulting in death) Last	c. Due to (or as	a consequenc	ce of):									
89	ntificate ing phy e as the		IF FEMALE:									-1		2 15-77	
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S, D	8 50	by	Part II. Other significant condit	ions contributing to death	but not resultin	g in the t	undertying o	ause give	en in Part	l.		obacco use cor Yes 2 ☐ No	atribute to		death? }Unknown
Record	The ate h page	Completed									24a. Was auto perfo 1 \(\text{Yes}		prior to death?	utopsy finding completion of 2 \(\square\) No	s available cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Hospital:		10	- 200 0	Oth	or		th (Check only o		thos (Can	niha)	
of	ding T. After fune	tion; To	1 Yes 2 No 27. Manner of Death Vatural 5 Pend	28a. Date of Ini (Month, D	ury 28	b. Time of Injury		28c. Injun Worl	4 🗀 14			how injury occu		City)	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of I	njury - At home atc. (Specify)	, farm, s	treet, factor	y, office			28f. Location (City or To	Street and Num wn, State)	nber or Ru	ural Route Nu	mber,
	ne Hospitai 24 hours a ne Funeral D	edical C	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the bes Il Examiner: On the basis and manner s	of examination	dge, dea and/or ii	th occurred nvestigation	at the tin	ne, date a pinion, de	nd place ath occu	and due to the rred at the time,	cause(s) and n date and place	nanner as e, and due	s stated. to the cause	(s)
)	To th withir To th	M	29b. Signature and title of certifications of the second s	er H	(att	2	29	c. Licens	e number	35	2	29d. Date sign	ed (Mont	n, Day, Year)	
5	136		30. Name and address of perso	20x	170	6	LAP	6	=	1	20	640			
	St Regist	ate rar	31. Date filed (Month, Ray Xea	0 4 2006 32. R	trar's Signature	4	Good	2							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Death **Physician** 2006 April 4:40 AM Opa1 Oleta Terrant /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Oakland 221 Red Oak Road Garrett If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2X F Yrs Director 235-80-3747 1919 WV 86 14 Usuel Residence of Decedent permit. Pagas 1 and 2 should be filad within 72 hours aftar daath with tha Manyland Department of Haalth and Mantal Hygiana. Important: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Madical Examinar must be notified as 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 1 No **Funeral Director** MD 0akland Garrett 10e. Street end Number 10g. Citizen of What Country? 10f, Zip Code 21550 221 Red Oak Road United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 ② No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Janitorial Schoo1 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Samue 1 Whisner Gussie Mae Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Sharpless, Daughter 605 Mary Drive, Oakland, MD 20b. Place of Disposition (Name of cemetery, cremetery or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens 4/12/06 Oakland, MD 22. Name and Address of Fecility Burdock-Durst Funeral Home 21. Signature of Funeral Service License 21 N. Second Street, Oakland, MD 21550 71. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Cerebrovascular Accident 2 weeks Examiner Due to (or es a consequence of): Examiner Peripheral Vascular Disease years attanding physician and I for usa as tha bunal-transit or Attending Physician: Tha law requiras that tha daath cartificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of). resulting in death) Last ed by tha a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tee 2 No 3 Probably 4 Unknown bean signed by ģ ata has bean signe paga 2 should be 24b. Were autopsy findings aveilable prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificata 25. Wes cese referred to-medicat 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpetient Certification: To 3□ DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation Injury Naturel To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af complataly filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner steted. Medicai 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature end title of certifie D15333 30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

Dr. Thomas G.

31. Dete filed (Month, Day, Year) APR 1

Johnson,

32. Registrer's Signeture

ORIGINAL

311 North 4th Street, Oakland, MD

21550

		-	1 - For State Registrar	State of	Maryland		artment <i>tificate</i>		alth and Meath		giene Reg. No. 0	06	120	72
			Decedent's Name (First, Middle,	Last)						2. Date of De	ath	V	3. Time of	Death
	Physicia	_	Tony Allen	Tarleton	1					Month	28,	2006	6:30	р ^м
	/Medic Examin		4a. Facility Name (If not institution,		_		4b. City, To	own, or Loc	cation of Death		4c. Co	unty of Death		-
			Shady Grove Ad	ventist Ho	spital			kvill				ontgome		
	Funeral			6. Sex 7. 1⊠M 2□F	Age (In yrs. I		If Under 1 Months		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Cour		
	Director	-	257-92-7386 Usual Residence of Decedent		5	1 Yrs.				08/13/	1954	Nort	h Caro	olina
	and and		10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside Cit	y Limits
	Mary	ğ	Virginia Virgin	ia Beach	Vi	rginia	Beacl	h					1 🗆 Yes	2 🔀 №
	r 28a	rec	10e. Street and Number				10f. Zip C				10g. Citizer	of What Cour	ntry?	
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	aiD	608 Redkirk Lan	e			23	462			Uni	ted Sta	ites	
	ge E	Funeral Directo	11. Marital Status	12. Was Deced Armed Forc	ent Ever in U.	S. 13.1	Was Decede	nt of Hispa y Cuban, M	anic Origin? (Sp Mexican, Puerto	ecify Yes or No Rican, etc.)	D- 14.	Race - Americ Black, White,		
9	filed within 72 hours after death with the Marylan Hygiene. Hygiene. At their hand natural; or ttems 23a or 28a-f show after the Madical Examinat must be notified at ent.	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	id 1⊠Yes 2 If Yes, Give	es? □NJ972 es:1982-	1993	1 🗆 Yes 2	XINO S	Specify:		Sp	ecity: Whit		
9500-GLZ	hour tural	ed be	15. Decedent's	L	BS; 1702		dent's Usual	Occupation	n			of Business/In		
ဂ်	in 72 n " n	olet	(Specify only highest	grade completed)	1	(Give	kind of work DO NOT use	done durir	ng most of work	ring				
717	i with	Completed	Elementary/Secondary (0-12)	Cotlege (1-4	ior 5+)	Elect	ronic	Tech	nician		Ele	ctronic	s	
		a	17. Father's Name (First, Middle, L	ast)				18	. Mother's Nam	e (First, Middle	, Maiden Su	тате)		
<u>la</u>	uld be Mental rrked o	To B	James Tarleton						Martha	Ellis_				
Maryland	and le ma		19a. Informant's Name/Relationsh	ip (Type, Print)					Number or Rur					
Σ,	and and sealth		Elizabeth A. Di	luzio / Sp	ouse	608 I			ne; Virg	inia Be		Virgini ion - City or To		52
0	T ite		20a. Method of Disposition 1 ☐ Burial 2 ☆Cremation	3 Removal from St	ate	emetery, crei	matory`or oth	er place)	l l					
	then then diury		4 Donation 5 Other (Sp		Ft.				ry 4/4/			wood, 1		nd
Baltimore,	permit. Pages 1 and 2 should be Depertinent of Health and Mental important: If item 27 is marked eny injury or other treumatic evonce.		21. Signature of Funeral Service C	f		10	040 Ro	ckvi1	of Facility Ite Fune le Pike	: Rocky	<u>/ille,</u>	ation (Maryla	100 208	
П			23a. Part1. Enter the disease of c shock, or heart failure. List of	complications that can only one cause on ea	used the death ch line.	n. Do not ent	ter the mode	of dying, s	such as cardiac	or respiratory a	ırrest,		Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition	_a Hepat:	ic Fail	ure							4 weel	
	/Medical Examiner		resulting in death)		r as a conseq								1	
Н	- Administra	_	Sequentially list conditions,	b. Metast	tatic (Cancer					_		Unknov	√n
	led isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00010(0	as a consequ	uence or,								
	al-trai	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a conseq	uence of):								
760,	death certificate be executed e attending physicien and id for use as the burial-transit	cal										1		
89	ifficat g phy as the													
Вох	eath certific attending p I for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregna th 2 ☐ Feta		∃Ectopic pre	gnancy			230	. Date of deliv	•	/aar
		sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (spe					Month	Day ^	/ear
<u>о</u>	that the de ed by the detached	Phy	9 Unknown	-					in Don't	22a Did	tobacco uso	contribute to t	ha nausa of d	leath?
Records,	The law requires that sie hes been signed t page 2 should be det	þ	Part II. Other significent condition	ns contributing to dea	un dut not res	uiting in the u	inderlying car	use given i	in raiti.		Yes 2 1		ably 4 🗆	
Ö	s bee	Completed								24a. Was		24b. Were auto	psy findings mpletion of c	available
	: The law cete hes page 2 ;	E O								auto perf	ormed?	death? 1 ☐ Yes		ause 01
ţ	sician: Th certificate rector, pag	Bec	25. Was case referred to medical	4				20	6. Place of Dea					
>	d is	ToE	examiner? 1 ☐ Yes 2 🔀 No	Hospitat: 1 ⊠ In	patient 2 🗆	ER/Outpaties			4 Nursing H	ome 5 Res	idence 6	Other (Speci	'y)	
0	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time o Injury		c. Injury at Work?		28d. Describe	how injury o	ccurred		
Sio	Attending r death.	cati	2 Accident investig	ot ba	4.1=1: 44.1-		М		s 2 □No	20f Location	/Ctrant and h	Number or Run	A Pauto Nue	has
Division of Vital	i. 5 th o	Certification:	4 ☐ Homicide determi	ned 200. Place	of Injury - At higg, etc. (Specif		reet, factory,	опісе			wn, State)	Variable of Mur.	ar Houte Num	oer,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	23a. Cartifer 1 & Certifying (Check only one)	g Physician: To the t Examiner: On the ba- and mann	sis of examina	wiedge, dati ition and/or in	Fi occurred a vestigation,	t the time, in my opini	data and place ion, death occur	and due to the rred at the time	cause(s) ar , date and pl	d marrier as a ace, and due t	tated. o the cause(s	;)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License n	umber		29d. Date s	signed (Month,	Day, Year)	
	- 2F 0		> × ///					D586	681		3/29	/2006		
	10+1		30. Name and address of person	who completed cause	of death (Iter	п 23а) (Туре,	, Print)				-,-,	,		
	[0,1]		Jude Alexander,					Driv	ve; Rocl	kville	Maryla	nd 208	50	
	Sta		31. Date filed (Month Day, Year)	4 2006	gistrar's Signa	ature	mente							
	Regist	ar	7 00 6 V C	E 2000	Mitted 1	~ 19								

and Mental Hygiene

For	State of Maryland / Department of Health
State Registrar	Certificate of Death

March 29, 2006

			- State Registrar	Cei	tificate of Death	Reg. N	2006 120/3
			1. Decedent's Name (First, Middle, Las	t)	2	2. Date of Death Month D	3. Time of Death
	Physicia /Medic		SONYA EILEEN V	ASQUEZ		March 28,	
1	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		Ac. County of Death
			637 Blossom D	rive	Rockville		Montgomery
	Funeral		5. Social Security Number 6. Se		If Under 1 Year ff Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birtholace (State or Foreign
	Director		258.41.1997	□ M 2 🖾 F 25 Yrs.			1980 Thomasville, GA
	D		Usual Residence of Decedent				
	nylar how		10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	e Ma	cto	Maryland Montgome	ery Silver	Spring		1 ☑ Yes 2 ☐ No
	th th	Jire.	10e. Street and Number		10f. Zip Code		Citizen of What Country?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow or other traumatic event, the Medical Exards at must be notified at	Funeral Directo	13540 Coachlamp I	ane	20906	U.	.S.A.
	dea F	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	ity Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
9	or It	正	1 Never Married 2 Married	1 🗆 Vac 2107 No	1⊠Yes 2□No Specity: Peruv		Specify: White
21215-0036	ours Fral',	d by	3 Widowed 4 Divorced	Year or Dates:			opecny.
5	72 h Instu	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16a. Deced de completed) (Give	dent's Usuaf Occupation kind of work done during most of working DO NOT use retired)	16b.	Kind of Business/Industry
7	within ene. then "	idu	Elementary/Secondary (0-12)	Correge (1-4or 5+)			-
	e filed within al Hygiene. cother then "	S		5+ Years	Paralegal		Law
p	d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (en Sumame)
Maryland	should be and Mental marked c	2	Carlos N. Vasqu	ıez	Linda G	G. Rush	
a	and and is m		19a. Informant's Name/Relationship (7		ng Address (Street and Number or Rural in		
≥.	and 2 ealth n 27 in		Linda G. Vasquez/	Approximate the last			ing, Maryland 20906
ore	S T T T		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	20b. Place of Dispo cemetery, crer	natory or other place)		Location - City or Town, State
Ĕ	Peges ment of ant: If It		4 □ Donation 5 □ Other (Specify	Fort Line	oln Crematory 4/04	/2006 Bre	entwood, Maryland
Baltimore,	E FOE		21. Signature of Funeral Service Licen	see 1	Name and Address of Facility NERA	I. HOME. T	NC.
œ	Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		Namen A. V.				ver Spring, MD 20904
			23a. Part1. Enter the disease, or compositors, or flear failure. List only	plications that caused the death. Do not ent	er the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
J.	Physician		Immediate Cause (Final		WEND OF CHE		Onset and Death
	/Medical		disease or condition resulting in death)	a. CONTACT SYGTGUN Due to (or as a consequence of):	THE CALL) <u> </u>	
п	Examiner						
	377	ē	Sequentially list conditions,	 Due to (or as a sonsequence of): 			
	d anslt	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events				
	al-tra	Exa	resulting in death) Last	Due to (or as a consequence of):			
68760,	certificate be executed ding physician and ise as the burial-transit			d			
89	ficate p phy is the	/Medical					
×	certi nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
Bo	death e atter	ciai	in the past 12 months?		Ectopic pregnancy Other (specify)		Month Day Year
P.O.	at the death c by the attend stached for us	Physiciar	9 Hnknown	9☐ Unknown			
	E 20		Part II. Dther significant conditions of	ontributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ds	signe d be	d by				1 Tes	2 No 3 Probably 4 Unknown
Records,	w requir been si should	Completed				040 1450	CAL Was a star of fading a salable
3ec	e law has	шb				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
=	: The cete had	S				125 Yes 2 □ N	
Vital	ysician: is certifice director, p	Be	25. Was case referred to medical examiner?	Hamitat	26. Pface of Death (
5	w 10	ဥ	1X Yes 2 □ No	Hospitaf: 1 Inpatient 2 ER/Outpatier			6 図Other (Specify) Temporary
ū	ding Phy h. After thi funeral	on:	27. Manner of Death 1 □Naturaf 5 □ Pending	28a. Date of Injury 28b. Time of Injury Injury	Work?	Bd. Describe how in	jury occurred Residence
sio	Attending r death.	cat	2 ☐ Accident investigation		10100 22510		
Division of	or Attend after death Director:	Certification:	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Specify)		City or Town Sta	and Number or Rural Route Number,
	ital c			RESIDENZE			OR; ROULVILLE, MD
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	cai	(Check only 2 Medical Exert	ysicien: To the best of my knowledge, death niner: On the basis of examination and/or in			
	the I	Medical	one) A	and manner stated.			
	0 = 0 5	2	29b. Signature and title of certifier		29c. License number	29d. D	Date signed (Month, Dey, Year)

State Registrar

RUBIO, MD ANA 32 Registrar's Signature 31. Date filed (Month, Day, Year) 0 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

OCME

			1- State of Maryland / Dep	artment of Health and Nartificate of Death	Mental Hygie	2006 12071.
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Robert Anthony White		March 1	7, 2006 06:30a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	ana	Ŭ.	Washington Adventist Hospital	Takoma Park		Montgomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 28,	9. Birthplace (State or Foreign Country)
	Director		577 - 58 - 8138	World Days Hours Will.	July 28,	1943 DC
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	Aaryla P eho	ъ		t Heights		XIXYes 2 □ No
	28a-i	Director	10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	with March	<u>=</u>	7211 Mason Street	20743	,09.	United States
	ne 23	era	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
(0	r iter	by Funeral	Armed Forces? 1 □ Never Married 2 □ X Married 1 □ XYes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
ලි	rai', c	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes ŽXNo Specify:		Specify: Black
20	be filed within 72 hours after deeth with the Maryland and Hygiene. All Hygiene defected of other then "netural", or items 23a or 28a-f show do other then "netural", or items 23a or 28a-f show event, the Madical Examiner must be notified at	Completed		edent's Usual Occupation e kind of work done during most of work	ing 16b	. Kind of Business/Industry
7	ithin 16.	dr.	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		
7	led w lygier her ti		11011	ck Driver	- 15: 11: 15:-	Private
Maryland 21215-0036	be fi	Be	17. Father's Name (First, Middle, Last) Robert Andrew White, Sr.		e (First, Middle, Maid Janie Smi	
₹	d Mer d Mer nark	ဥ		ing Address (Street and Number or Rui		
<u>R</u>	d 2 s th an t7 ie i	1		Longfellow Street		
<u>ත</u>	Heal Heal tam 2		20a Method of Disposition 20b. Place of Disp	osition (Name of		. Location - City or Town, State
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. By find many in marked other than "natural; or items 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.		1 Executar 2 Cremation 3 Hemoval from State _	etion Cem. 3/29	/2006 C1	inton, Maryland
≣	ertm ortar fnjur		(-)	Name and Address of Facility Alexander S. Pope		
ä	P G T P S		Variable Kelling	5538 Marlboro Pike	Funeral Ho Forestvil	mes, P.A. le. Md. 20747
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, by heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition CARDIAC		MIA	Onset and Death
1	/Medical		resulting in death) Due to (or as a consequence of):	7,1412		
	Examiner		Sequentially list conditions, b. CARDIOM	YOPATHY		
	P #	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury			
	and -trans	Cam	Cause (Disease or injury that initiated events c. Pue to (or as a consequence of):			
8760,	cate be executed physicien and s the burial-transit	a E	Due to (or as a consequence or).			
387	phys the	dlcai	d			
9 X	eath certifi attending for use as	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	that the death certifined by the attending to detached for use as	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O.	by the	hys	9 Unknown 9 Unknown			
ري ت	w requires that been signed by should be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
Ĕ	en sig	ed	Vialeles Mellilus, H	yeutencian,	1 ☐ Yes	2 No 3 Probably
သူ	law re as be 2 sho	plet	Renal Failuse		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Ě	The lav	Completed			performed	? death? No 1 Tes 2 No
ita	ien: artifica ctor,	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
<u>~</u>	hysic his ce I dire	2	1 ☐ Yes 2 ☐ No Hospital: X Inpatient 2 ☐ ER/Outpatie		me 5 Residence	6 ☐Other (Specify)
ב	Ing P		27. Manner of Death ↑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how in	njury occurred
S	tend death tor: /	cati	2 Accident investigation	M 1 Tyes 2 No	006 1	
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	treet, factory, office	City or Town, Si	t and Number or Rural Route Number, late)
	spital ours neral filled		29a. Certifier 1XXertifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place,	and due to the cause	e(s) and manner as stated.
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within £4 hours alter death. To the Funeral Director: Alth. To the Funeral Director: Alth. Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			1 Tucolilita 11	D 42 44	ON	March 28,2006
2	(10)		30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)	1	7/ 7/2
			Dr. Yudh Gupta, 7600 Carroll Ave.	Takoma Park, Md.	20912	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3 2006 P. Registrar's Signature	de		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 3:55 P M WILLIS T. WILSON, SR. March 30 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House-Montgomery Hospice Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1⊠M 2□ F 77 069.20.4055 Oct. 14, 1928 New York Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or items 23a or 28a-f ehow the Medical Examinar roual be notified at 1 Tryes 2 □ No Silver Spring Director Maryland Montgomery 10f. Zio Code 10g. Citizen of What Country? 10e. Street and Number 20910 U.S.A. 2107 Linden Lane death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? amed Folces? 1 ⊠Yes 2 □ No Korean If Yes, Give Year or Dates: War filed within 72 hours after 1 ☐ Never Married 2 ☑ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education 5+ Years Community Service Leader Ith and Mental Hygin 27 is marked other traumatic event, II other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Marguerite Ayers Harrison В. Wilson, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Heelth a importent: if item 27 is any injury or other train once. 2107 Linden Lane, Silver Spring, Maryland 20910 Wilma Bernadine Wilson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Fort Lincoln Crematory04/10/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 21. Signature of Funeral Service Line ns 11800 New Hampshire Avenue, Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Colon Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner Attending Physician: The law requires that the death certificate be executed iding physicien and ise as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medicai as the t IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Month Dav Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by s been signe should be c 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2X No 1 🗌 Yes 2 No certificate 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 6 COther (Specify) Hospice ٥ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division Injury 1 K Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 5 within 24 hours a Hospitei 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 9 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of o April 1, 2006 D-35635 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, MD, 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 2006 JOHN PERSHING WHITE, JR. 06:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** KENT 206 MT. VERNON AVE. CHESTERTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. AT RTL 29, 1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** Months Days 1∰M 2□F 218-48-8334 57 Yrs Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or Items 23a or 28a-f ehow traumatic event, the Medical Exercities as CHESTERTOWN 1 XYes 2 □ No MD KENT Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 206 MOUNT VERNON AVE. death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural" ~ "- any injury or other traumatic even." 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: WHITE þ 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LAW ENFORCEMENT OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN PERSHING WHITE, SR. KATHRYN SPENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET SLAMA/COMPANION 206 MOUNT VERNON AVE., CHESTERTOWN, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place)
ST. PAUL S CEMETERY 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 03/30/2006 CHESTERTOWN, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
LLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
10 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** mia disease or condition resulting in death) /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the attending physician and hed for use as the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown I signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 2 🗷 No 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. Diractor: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 usuel a. Sley eath (Item 23a) (Type, Print) 555 Cynwood or Easton MS grati State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland	d / Department of H Certificate of I		91	106	12077
			Registrar Decedent's Name (First, Middle, Last))	Vertificate of t	Jeani	Reg. No. 2. Date of Death	200	3. Time of Death
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	Funeral		5. Social Security Number 6. Sex		ast birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	9. Birth	place (State or Foreign
	Director		219-60-1311	M 2× 53	Yrs. Months Days	Hours Min.	8 8 19	52 M	reyland
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98	hours after death with the Maryland turel', or Items 23a or 28a-f ehow at Examitter roust be routified at		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, specify Cuba 1 ☐ Yes 2 No	in, Mexican, Puerto F Specify:		Black, White, Specify: R	aV.
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Maryland	shou and M		19a. Informant's Name/Relationship (Ty)	rpe, Print)	19b. Mailing Addres (Street a	and Number or Rura	Poute Number, City or	Town, State, Zi	Code) 2/62/
	1 and Health tem 27		SOGNOYICA GIC	ICINS 20b. Pl	ace of Disposition (Name of	wood Ct.	NOT 1-13 C	Cation - City or T	DWW MD
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alti	permit. Pages Department of Important: If i any injury or anse.		21. Six sture of Funeral Service Licence	- 010	22. Name and Addres	ss of Famility	10,000	/	1
8	205 2 3	100	23a. Pag1 Enter the disease, or compli	nuce	Bluttes Do not enter the mode of dying	with tu	nelalion	U WOLT	Approximate
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ì	/Medical		disease or condition resulting in death)	Due to (or a a consequ	ience of):				bmos
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Examiner **Funeral** Director or 28a-f ahow iteme 23a filed within 72 hours after death Baltimore, Maryland 21215-0036 "natural", or ... Pages 1 and 2 should be fil tment of Health and Mental H tent: if item 27 is marked ott ilury or other traumatic ever

permit. Page Department of Important: if any injury or once. Physician /Medical Examiner

attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. ate has been signed i paga 2 should be det After this certific funerel director, efter death. the à within 24 hours el To the Funeral D

1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** APRIL 2:53A. James Alvia Wentz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death CHARLES INDIAN HEAD 4040 DONCASTER DRIVE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 25, 1977 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F 216-13-3738 28 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No Maryland Charles Indian Head Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3890 Smallwood Church Road 20640 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi Elementary/Secondary (0-12) Coflege (1-4or 5+) Welding Foreman Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Erma Ruth Farnsworth David Lee Wentz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shaunda Wentz Wife 3890 Smallwood Church Rd., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) April 6,2006 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Pisgah, Maryland Nazarene Church Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Multiple injuries Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 No 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Pface of Death (Check only one) examiner? 1∑Yes 2□ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE မ 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred was ejerted Injury Driver of ATV 1 Natural 5 Pending 1 ☐ Yes 2 No 2 Accident tound 1:15 M Found 4-1-06 investigation Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4046 Doncaster Dr 4 Homicide Head Indian (Troth 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) L min O.C.M.E. APRIL 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -1 NG 111 PENN STREET BALTIMORE, MARYLAND 21201 32. Resstrar's Signature 31. Date filed (Month, Day, Year) State sache. APR 0 4 2006 Molus Registrar

			For State Registrar	State of Ma	aryland .		artment of F rtificate of				jiene	6	12079
	5 1 -1-1		1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Carroll V	VISNEY	Jr.				A	1271	1, 20		4:45PM
	Examin		4a. Facility Name (If not institution, give		13		4b. City, Town, o	r Location	n of Death	_	4c. County		
			Mestminister	mising	1),			195tr				ION	
	Funeral		5. Social Security Number 6. So	ex 7. / /g ☑M 2 □ F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	. Date of Birth (Month, Day	, Year)	9. Birth	hplace (State or Foreign untry)
	Director		217-18-8390 Supply Supp	*	85					05-18-	-1920	Ma	ryland
	land		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
	Mary -teh	ō	MD Carro	11	Fi	nksk	ourg						1 ☐ Yes 2 ☐ No
	28s	Director	10e. Sfreet and Number		h		10f. Zip Code			1	10g. Citizen of V	/hat Co	untry?
	3e o		1439 Wesley	Road				2104	8		T 11	SA	
	deatl	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of I f Yes, specify Cub			y Yes or No-		- Ame	rican Indian,
စ္	or ite	F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 1 If Yes, Give	No		1 17es, specily cub 1 □ Yes 2 □ No	Specif		zari, etc.)		k, White	
ဗ္ဗ	hours after death with the Maryland turel', or tteme 23e or 28a-f ehow al Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			TO TOS ZEXTO	Specii,	,. 		Specily	wn	ite
5	72 na 12	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	1	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mo	ost of working		16b. Kind of Bu	siness/l	industry
12	within ene. then "	E	Elementary/Secondary (0-12)	College (1-4or 5				,	1				
42	be filed withintal Hygiene. Ind other thereword, the Meneral Control of the Meneral Control		17. Father's Name (First, Middle, Last)			err	Employ				Far Maiden Sumam		.g
Maryland 21215-0036	d ta b	o Be	Carroll Donal	d Jackso	n Wis	ner					Knigh	,	
ary.	d 2 should th and Men 7 is marke treumatic	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Address (Street						Tip Code)
	d2 Tha		Lois E. Calhoun	- Niece	e 5	24	Stone Re	d.,	Westm	inste	r, MD	211	58
Baltimore,			20a. Method of Disposition ★□ Burial 2 □ Cremation 3 □	Clamanal from Chata	20b. Place	e of Dispo	sition (Name of natory or other pla	ce)	Date	9	20c. Location -	City or 1	Town, State
Ē	permit. Pages 1 Department of H importent: If its eny injury or ot ance.		4 Donation 5 Other (Specify		Wesl	ey i	JMC Cem		04-04	-06	Hampst	ead	. MD
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications thaf caused one cause on each lir	fhe death. [ne.	Do not ent	er the mode of dyir	ng, such a	is cardiac or re	espiratory arr	est,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	(Cere	L lad	nfar	retion				10 4875
	/Medical Examiner		resulting in death)	Due to (or as									/
		70	Sequentially list conditions,	b. — Dua to (or as	# ECOSOTION	ne offe							
	hed nsit	Examine	if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	((
Ć,	execu n and ial-tra	Exal	that initiated events resulting in death) Last	C. Due to (or as	a consequen	ce of):							
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9	tifica ng ph as th		15 FG1111 G		-								
Вох	eath certific attending p	7	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnanc	,			23d. Dat		,
	death he att	stole	in the pasf 12 months? 1 Yes 2 No	4☐Pregnant at 9☐Unknown			Other (specify)				Mor	ith	Day Year
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	ires the signer	þ	Part II. Other significant conditions of	onthouting to death b	ut not resuttin	ig in the u	nderlying cause giv	en in Pan	t I.	236. Did to			the cause of death?
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0	g Physie ter this	-	27. Manger of Death	28a. Date of Inju	ry 28	b. Time o					ow injury occurr		ny)
<u>6</u>	E +5 %	atlo	1 Natural 5 Pending 2 Accident investigation		y rear)	Injury		Yes 2	□No				
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	itai o irs aft rai Di	Cer											
	To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier 1 T Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	f examination	dge, deat and/or in	n occurred at the till vestigation, in my d	me, date a pinion, de	and place, and eath occurred	d due to the c at the time, d	ause(s) and ma late and place, a	nner as ind due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	TANC AA	el.	0	29c. Licens				9d. Date signed		**
	WIL		· X	and the second	1/2		100	0299	743		April	3,	2000
	M20		30. Name and address of person who	completed cause of d	leath (Item 23		Print)	esm	inster	M10	21157		
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature		- 1		-/-	1			
	Registr		APR 0 4	2006	ELAST J	&	Corner !						

06-02277			Pleas	e Type or	Print in	Black Ind	lelible Ink						
Wolfe, Brian	e	1- For State Registrar	tate of Maryla		artment d rtificate d		nd Mental H		Reg. No	200	06 120	8	
Physicia Medical Examir		1. Decedent's Name (First, Midd Brian Bradfo						2. Date of De Month April 2, 2	Day	Year	3 Time of Death 11:30AM		
i.e.		4a. Facility Name (if not institution	on, give street and nu	umber)		4b. City, Town, o	or Location of Death			County of [Death		
		310 East Crook Stree	et Apt. 3			0ak1	and	Garrett					
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Ye			Birth (MM/D	D/YYYY) 9	Birthplace (State or For Country)	eign	
Director		217-15-2251 Usual Residence of Decedent	1 XM 2 F	24	Y			Oct.	15,	1981	Oakland, MD)	
w any		10a. State 10b. County		10c. City,	Town or Loca	ation					10d Inside City Lin		
ith the Maryland 23a or 28a-f show notified at once.	Director	MD Garr	rett	0	akland	10f. Zip Code			10g. Citize	n of What	1 X Yes 2	No	
or 29	ire	825 High Stree	\ +			21550							
eath w items ust be	by Funeral	11. Marital Status 1 X Never Married 2 N	12. Was Dec Armed F 1 Yes Vorced If Yes, Give Yes or Dates:	2 X No	1	/as Decedent of H Yes, specify Cuba		Rican, etc.)	lo- 14	4. Race - A White, e	hite		
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2121 uld be f Mental marked: event,	o Be	Laurance B. Wo			19h Mailir	na Address (Stra	Pamela eet and Number or I	Gold:	sboro	ugh	State Zin Codo)		
e, M I and 2 Health item 2	-	Pamela Smith, 20a. Method of Disposition 1 X Burial 2 Crematio	Mother	20b. I	99 (Oak Stre	et, Apt 1		kland	, MD	21550 ty or Town, State		
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service	Specify:		lfe Cen	netery	4/5 ss of Facility Bur	/06 dock-Di			e, MD al Home		
Physician /Medical		23a Part I. Enter the disease, or failure. List only one cause	Complications that complications on each line.	aused the death.		21 N.	Second S	treet.	0akla	and.	MD 21550 Approximate Inter Between Onset a		
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	ne and tra consequence o	madol ir	ntoxication	n				Death		
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executed in and il - transi	cal	V	d	//00	DTT 07 (O C 10	7 0054 4/40	los m					
O, be est siciar	-	X UNPENDED	AMENDED	item#23a,	PII,2/,2	28a-i,perM	E , G854 , 4/19	/06 TT					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	the 1 Live b	ant at time of de	2 F	etal death 3 other (Specify)	Ectopic pregna	ancy		Date of del onth	ivery Day Year		
D. B the d by the	F)	Part II. Other significant condit			esulting in the	underlying cause	given in Part I.	23e. Did	tobacco use	e contribut	e to the cause of death?		
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Division of Vital Records, P.O. Box rat or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the arte led in by the funeral director, page 2 should be detached for I	Completed							24a. Was auto perfe 1 Yes	psy ormed?	prior deat	e autopsy findings availal to completion of cause o h? Yes 2 No		
ian:	Bec	25. Was case referred to medica				26.Plac	ce of Death (Check	only one)					
Vit hysic this o	0	examiner? 1 ✓ Yes 2 No	Hospital: 1	inpatient 2	ER/Outpatien	nt 3 DOA	Other Nursin	g Home 5	Residenc	e 6 🗸 C	other Scene		
n of oding P. h. After e funera	ion: T	27. Manner of Death 1 Natural 5 Peni	28a. Date (Month	of Injury , Day,Year)	28b. Time of		ury at Work? Yes 2 🔀 No	28d. Describe unk	how injury	occurred			
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	2 Accident Inve	estigation unk	e of Injury - At ho unk	unk ome, farm, stre	eet, factory, office				Number o	r Rural Route Number, Ci	ity	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Finneral Director: After this certificompletely filled in by the funeral director.	Medical Co	29a. Certifier 1 Certifying P	Physician: To the best aminer: On the basis of and manner s	st of my knowledg				due to the cau					
→	Me	29b Signeture and title of certific		c ord	/		se number .M.E.			te signed 3, 2006	(Month, Day, Year)		
		30. Name and address of person Carol Allan, MD A	n who completed caus ssistant Medical		,	n Str e et, Baltii	more, MD 2120	01					

State

Registrar DHMH 17 Rev 1/2001 OCME 10/2003

31. Date filed (Mo Kry (Year) 5 2006

Syrath

32. Registrar's Signature

			For State Registrar	State o	f Marylan	-	artment <i>tificate</i>			nd Me		iene	006	1	2081
	Physici		Decedent's Name (First, Middle Ruby Joyce Wol	. ,						j	2. Date of Dear	Day	Year 200		me of Death
) }	/Medic Examin		4a. Facility Name (If not institution		mber)		4b. City, T	Fown, or i	ocation of			-	ounty of Dea	-	<u> </u>
			Washington Coun					erst		4 Mag. T			shingt		
H	Funeral Director		5. Social Security Number 291–36–0122	6. Sex 1 □ M 2 1 F	7. Age (In yrs. 71	Yrs.	If Under Months	Days	Hours	Min.	 Date of Birth (Month, Day) 12/28/1 	Year)			tate or Foreign 7an1a
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insi	ide City Limits
	Maryli	ţor	Maryland Washi	ngton		erstow									Yes 2□No
	n the	Director	10e. Street and Number	ngcon	liag	EIB LOW	10f. Zip	Code			1	0g. Citize	n of What Co	ountry?	
	23a c		202 East Washi	ngton St			2174	40				U.S.	Α.		
936	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene detections 23a or 28a-f show other than "natural", or flems 23a or 28a-f show event, It a Medical Fraction must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Fo	2 X No		Was Decede f Yes, speci 1 ☐ Yes 2		panic Origi , Mexican, Specify:	in? (Spec Puerto P	cify Yes or No- tican, etc.)		. Race - Ame Black, Whit pecify: Wh		an,
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21	han "c	mple	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. L	DO NOT use	e retired)		Or WOIKIII	9		_		
22	filed within 72 Hygiene. other than "nal ent, Ir e Medici		12 17. Father's Name (First, Middle,	[ast]		Ribbo	n Prod			's Nama	(First, Middle,		ufactu	ring	
_	d be f ental h	o Be	Arthur Thomas S								rene Me		umamoj		
<u>Z</u>	2 should be and Mental I is marked or raumatic eve	ဥ	19a. Informant's Name/Relations			19b. Mailin	g Address	(Street a			Route Number		Town, State, a	Zip Code)	
Š	and 2 ealth a m 27 is		Patricia A. Ch	urchey/ D	aughter	P.O.	Box 2	24510) Jacl	kson	ville F	lori	da 322	41	
e G	of He		20a. Method of Disposition 1 Durial 2 Cremation	3 Permoval from		Place of Dispo cemetery, cren	sition (Nam natory or oti	e of her place)	Da	ate	20c. Loca	ation - City or	Town, Sta	ate
Ĕ	Pag ment ant: i		4 □Donation 5 □ Other (S	ipecify)	Sm	ithsbu							hsburg		/land
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Mente important: if item 27 is marked any injury or other traumatic e QDCs.		21. Signature of Funeral Service	Licensee		1	. Name and	Address	of Facility v1van	Rest ia a	Haven ve Hage	Fune rsto	ral Ch wn Mar	apel yland	1 21742
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the deat each line.	h. Do not ente	er the mode	of dying	, such as c	ardiac or	respiratory arr	est,		Interv	ximate al Between and Death
į.	Physician		Immediate Cause (Final disease or condition resulting in death)		1 monin		- STA	PH	4 400	o cc	l L			Oliset	and Death
	/Medical Examiner			Due to	(or as a conseq		20-/								
	裳	er	Sequentially list conditions if any, leading to immediate	b. —	(or as a conseq	HH71 uence of):	/ 120	7	-1-31				- 1		
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	5 TH	ROAT	CAN	CER								
Ö,	e exec ian ar urial-ti		resulting in death) Last		(or as a conseq										
8760	icate be executed physician and s the burial-transit	dicai		d. 04.	SPHAN	14									
9 X	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							23	d. Date of de	iverv	
.O. Box	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2∏Feta nantat time of d own		Ectopic pre Other <i>(spe</i>						Month	Day	Year
مَ	that the de led by the s detached f	/ Ph	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	nderlying ca	use givei	n in Part I.		23e. Did to	acco use	contribute to	the caus	e of death?
Vital Records,	w requires that been signed to should be det		CACITO	4 A							1 🗆 Y	es 2 🗆	No 3□P	obably	4 □Unknown
ဝွ	s bee	plete									24a. Was a	n	24b. Were at	utopsy find	dings available
¥.	The lav	Completed									autops perfor	ned?	death?	completion	
= ta	ysicien: The is certificate his director, page	Be (25. Was case referred to medica examiner?							of Death	(Check only on				
5	Physic this co al dire	은	1 Yes 2 No			ER/Outpatien			4 14012		e 5 Reside			cify)	
u O	ding F h. After funer	tion:	27. Manner of Death 1 ☑Natural 5 ☑ Pendir 2 ☑ Accident investi	9	of Injury th, Day Year)	28b. Time of Injury	м 28	3c. Injury Work	at ? es 2 ⊡N		8d. Describe h	ow injury (occurred		
Division of	Attender death rector:	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At he	ome, farm, str					8f. Location (S	reet and	Number or R	ural Route	Number,
á	s after	Certification:	4 Homicide	buildi	ing, etc. (Specif	(y)					City or Town	n, State)			
	To the Hospitel or Attending Physicien: which 24 hours after deals as a feet deals To the Funeral Director: After this certifics completely filled in by the funeral director; to	Medical C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the Examiner: On the band man	best of my kno asis of examina ner stated.	owledge, death	occurred a vestigation,	at the time in my opi	a, date and nion, death	place, an	nd due to the c d at the time, d	ause(s) ar ate and p	nd manner as lace, and due	s stated. to the ca	use(s)
	To the within To the Comp	Ň	29b. Signature and title of certific					License			^ 2	9d. Date	signed (Mont	h, Day, Ye	ear)
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4	i11		30. Name and address of person			n 23a) (Type,	Print)	Δ			ROST,	, I .A			
	H- Sta	to	31. Date filed (Month, Day, Year,	160 - W (N.5/)	ogistrar's Signa		5 731	1570)	17A-M	M 37	ROCT,	HT	40141	DWA	J NID
	Registr		APR 0	4 2006	Black same	19. 4	media	1							

			201	partment of Health and Me <i>rtificate of Death</i>		ene 2005	2082
Ś			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Ruperta Ramos Aberin		APRIL	16 2006	7:45 P.M.
	Examin		4a. Facility Name (If not institution, give street and number) 1614 Bridewells Ct.	4b. City, Town, or Location of Death Joppa		4c. County of Death Harford	
	Funeral Director		5. Social Security Number N/A 6. Sex 1 M 2 F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Oct. 30,	Year) 1916 Phili	ice (State or Foreign y) ppines
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		100	d. Inside City Limits
	e Maryli 3a-f eho	ctor	Maryland Harford	Јорра			1 □Yes 2X No
	h with th	ai Dire	100. Street and Number 1614 Bridewells Ct.	10f. Zip Code 21085		g. Citizen of What Countr ülippines	y?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural" or itams 23e or 28e-f ehow any injury or other traumatic event, the Medical Eventh ethical the Incilliant and Once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Fil	
2-0	72 hou	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work	ina 1	6b. Kind of Business/Indu	ıstry
Maryland 21215-0036	d within giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired) Homemaker		Own Home	
land	id be file ental Hy kad oth ic evant	To Be (17. Father's Name (First, Middle, Last) SEVELO Ramos	18. Mother's Nam	e (First, Middle, M 'LA	laiden Sumame) Maurici	.0
Mary	d 2 shouth and M		19a. Informant's Name/Relationship (Type, Print) Ms. Emilia Javier (grand-daughter) 1	iling Address (Street and Number or Run			Code)
	Heall tam 2	3	20a Method of Disposition 20b. Place of Dis	position (Name of		Oc. Location - City or Tow	m, State
IOE	Pages ent of nt: If i		1 U Buriai 2 (ACremation 3 U Removal from State)	rematory or other place) Chematory 4/20	/2006	Baltimore, M	aruland
Baltimore,	permit. Departm Importal any inju		21. Six hture of Funeral Service Licensee	22. Name and Address of Facility Sch 9705 Belair Rd., Bo	himunek 1	Funeral Home	
8760, -2	Cate be executed Medical Medical Examiner the private transit	ai Examiner	23a. Part1. Erther the disease, or complications that caused the death. Do not death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Batween Onset and Death
P.O. Box 687	death certifi e attending d for use as	Physician/Medicai		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliver Month	Y Day Year
	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significent conditions contributing to death but not resulting in the ARTERIOSCLERCTIC CARDICS			acco use contribute to the s 2 ❷No 3 □ Proba	e cause of death?
of Vital Records,		Completed			24a. Was an autopsy perform	prior to com	sy findings available pletion of cause of
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?		h (Check only one		
ion of \	ding Phys n. After this funeral dii	ation; To	1 Yes 2 No Hospital: 1 Inpatient 2 FNOutpat 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at	ome 5 Preside 28d. Describe ho	nce 6 □Other (Specify) w injury occurred	
Division	al or Atta after de: Diracto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	eet and Number or Rural , State)	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as sta ite and place, and due to	ited, the cause(s)
	To tha I within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, D	
)			Wilhelmia Poglirana, Mi	Do01502	21	APRIL 1	7,2006
	6		30. Name and address of person who completed cause of death (item 23a) (Type (217 SIEITMENS RUN RO	AD STE, E B.	ALTIM	CRE, MI	7 21221
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type (CIT STEMMENTS RUN RO) 31. Date filed (Month, Day, Year) APR 1 8 2006	against the same of the same o			

				eartment of Health and Mental Hygiene ertificate of Death Reg. No. 0 0 6 1 2 0 8 3
3	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
-	/Medic Examin	al	Katherine M. Brashears 4a. Facility Name (If not institution, give street and number) Peartree Assisted Living	April 16 2006 7:49 A M 4b. City, Town, or Location of Death Pasadena Anne Arundel County
- 3	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 18–14–5331 7. Age (In yrs. last birthday 98 98.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 2, 1907 Mary Land
	land ow	8	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	
	e Many se-f sh	ctor	Maryland Anne Arundel Pa	sadena 1□Yes 2♥No
	with th	Director	10. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	death ms 23	Funerai	1941 Orchard Point Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show myn njury or other traumatic avant, the Madical Exemples must be notified at ance.	þ	Armed Forces? 1 Never Married 2 Married If Yes 2 Me Yes	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify: Specify: White
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nd	be filed ital Hygie d other svant, it	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
7	should and Men a marke umatic	은	William O. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Carrie M. Payne ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and 2 s salth an n 27 ts i		Wayne L. Brashears (Son) 8310	
ore,	of Hear		20a. Method of Disposition 20b. Place of Disposition cometary, cre	osition (Name of Date 20c. Location - City or Town, State amatory or other place)
Baltimore,	t. Peges rtment of I rtant: If it		4 Donation 5 Other (Specify) Glen Hav	en Mem Park 04-19-06 Glen Burnie, Maryland
Ba	permit. Departrimporta		21. Signature of Funeral Service Licensee	P. Name and Address of Facility In Cully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122
8760, X	Physician hysician and physician and physician and physician transit the print transit	dicai Examiner	23a part. Enter the disease, or complications that caused the death. Do not enshook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death Gradiomy of Athy Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-0000 Approximate Interval Between Onset and Death 50-00000 Approximate Interval Between Onset and Death 50-0000000000000000000000000000000000
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rds, P	w requires that been signed should be dei	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 Yes 3 Probably 4 Unknown
Il Records,	The law requ	Completed		24a. Was an autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No.
Vital	Physicien: Th r this certilicate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 Dec Hospital: 1 Innatient 2 ER/Outpatie	26. Place of Death Check only one
Division of	To the Hospitel or Attending Phys within 24 hours eliter death. To the Funerel Director: After this completely filled in by the funeral di	\vdash	27. Manner of Death 1 Chatural 5 Pending 2 Accident Accident 28a. Date of Injury (Month, Day Year) Injury	Thursday Home 5 Hesidence 6 Zother (Specify House)
DIX	tei or Att rs etter de el Directo ed in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitei or within 24 hours ette To the Funarel Direct completely filled in Inc.	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	th occurred at the time, date and place, and due to the cause(s) and manner as stated investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
)	To To Com	2	29b. Signature and title of certifier	29c. License number D2094 O4/17/06 Print) Adison Park Orive, Gla Derne, Mad, 2106/
	8		30. Name and address of person who completed cause of death Item 23a) (Type Elliott For bary MD. 1411 M	edison Park Brive, Gla Birme, und, 21061
. 16	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 8 2006	Jarle

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nő. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Year **Physician** CARL HENRY BERGSTROM 200 (T /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROLAND PARK PLACE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | 1 / 1 1 / 1 9 1 6 5. Social Security Number 9. Birthplace (State or Foreign Country)
MASS • 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 ☐ F 023-09-8184 89 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itama 23a or 28a-f ahow any njury or other traumatic avant, the Madical Exemples. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 830 WEST 40TH STREET 21211 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ ENGINEER ENGINEERING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CARL O. BERGSTROM RUTH (UNKNOWN) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADRIENNE BERGSTROM (WIFE) 830 WEST 40TH ST. UNIT 217 BALTO., MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) GREEN MOUNT 04/21/2006 BALTO CITY, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY W. JEN
16924 YORK R W. JENKINS & SONS C YORK RD MONKTON, MD. ar Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BKAIN STEM Physician /Medical Examiner exel rovaseula Assex Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? deteched for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 2 No 1 ☐ Yes or Attanding Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 9 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannes of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours efter To the Funeral Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Calelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tabration ISBULL ? 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2006 Registrar

			For State Registrar		State	of Mar	yland / [rtmen				lental Hy	gien Reg. N		6	120	85
	Physici	an	Decedent's Name (First, Michael Control of the	116									2. Date of De Month		Y, E	Year ZIŽIE	3. Time o	
	/Medic Examin	cal	Sr. M. Bene 4a. Facility Name (If not instituted and Jose						4b. City,	Town, or	Location (of Death			. County	of Death	9:15 imore	
	Funeral Director		5. Social Security Number 219-18-4956	6. Sex]м Ж □ F	7. Age (8 3	In yrs. last bir	thday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Da 8 – 15 –	rth ay, Year 22)	9. Birthp Cour	place (State htry) M.D	or Foreign
	deeth with the Maryland time 23a or 28e-f show I mast be notified at	tor	Usual Residence of Decedent 10a. State 10b. Cour M D B a 1 m	nty I i m o	re		Oc. City, Tow									1	0d. Inside C	City Limits
	or 28	Olrec	10e. Street and Number						10f. Zip					10g. C	itizen of V		ntry?	
	e 23a	rail	6806 Bellon				:- 11.0	140.1	212			-1-0 (0-		_	USA			
200	urs after de Ni', or item charabact	by Funeral Director	11. Marital Status 1 XNever Married 2 □ M 3 □ Widowed 4 □ Divord	arried	12. Was Dec Armed F 1 Tes ff Yes, G Year or I	orces? 2∭No ive	er in U.S.	1	Yes, spec		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	0-	Blac Specify	k, White,		
D-C12	ithin 72 hou ie. ien "naturi i.Medical E	Completed	15. Dece (Specify only hig Elementary/Secondary (0-12	hest grade	e completed) (1-4or 5+)		(Give life. L	lent's Usua kind of woi DO NOT us	rk doné d se retired)	uring mos				Kind of Bu	siness/In	dustry	
7	iled wi dygien ther th nt, the		1 2 17. Father's Name (First, Midd	le (251)	_4			R	elig	ious			r e (First, Middle		eli			
yland	id be f ental h ked of	To Be	John Franc		radv								y Biss			θ)		
Mary	shoul	ř	19a. Informant's Name/Relation	onship (Ty	pe, Print)	iai	011 G 19b	. Mailin	g Address	(Street a			al Route Numb			State, Zip	Code)	
ມ <u>ົ</u>	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28e-f show any injury or other traumatic event, the Medical Engrithed market. Any injury or other traumatic event, the Medical Engrithment has inclined at Angle.		Sisters Of 20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematic	nerc	y 01	der	20b. Place o cemete	f Dispo	sition (Nan	ne of ther place	9)		arkway Date	20c. l	ocation -	City or To	wn, State	1239
Salumor	t. Pag tment rtant:		4 Donation 5 ☐ Other	(Specify)			Wood						1-06	Ba1	time	ore,	MD	
D D	permi Depa impo any ir		21. Signature of Eurorah Serv	Ce cicenso					. Name an			DI	adley-					HOm
	Physician		23a. Part1. Enter the disease shock, or heart failure. I tramediate Cause (Final disease or condition	or compli ist only or	ne cause on	each line.	e death. Do	not ent	er the mod	e of dying	g, such as	cardiac			Ra.	21.100.700	Approxima Interval Be Onset and	tween Death
	/Medical Examiner		resulting in death)		Due to	o (or as a o	consequence IS	of):									HOURS	
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	【 。	Due to		consequence											
8/00,	certificate be executed rding physician and ise as the burial-transit	Ical	leading in death) cast	L.	Due to	(or as a	consequence	of):										
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ras, r	w requires that the been signed by th should be detache	b	Part II. Other significant cond	litions cor	ntributing to	death but	not resulting i	n the ur	nderlying c	ause give	in in Part I						ne cause of bably 4	
necol	The law ate hes b page 2 sl	Completed						····					24a. Was auto perfe 1 \(\text{Yes}	psy ormed?	C	leath?	psy findings mpletion of	available cause of
VII	ysicien: is certific director,	Be	25. Was case referred to med examiner?	_	lospital:	101				Othe			h (Check only					
ō	ding Phys h. After this funeral di	7. To	1 Yes 2 No 27. Manner of Death		1 (4	Inpatient of Injury oth, Day Y	2 ☐ ER/Ot	Time of		8c. Injury Work	4 140		me 5 Res 28d. Describe				y)	·
VISION	Attending Physicien: r death. ector: After this certific by the funeral director,	atlor	2 1100,000	stigation	(Mo	nth, Day Y	(ear)	fnjury	м		? ∕es 2 🗆							
		Certification;	4 Homicide det	ild not be ermined	buile	ding, etc.							28f. Location (City or To	wn, Stai	'e)			nber,
	To the Hospital or within 24 hours effe To the Funeral Dis completely filled in	ledical	29a. Certifier 1 Certi (Check only 2 Medione)	ying Phys cal Examin	ner: On the	basis of ex nner state	xamination ar	a Jaath nd/or inv	estigation,	, in my op	nion, dea	id place; ith occur	and due to the red at the time.	cauee(i , date ar	d place, a	and due to	the cause(s)
	To Too	Σ	29b. Signature and title of cert	itier 7 –	ml)				: License)258				29d. D	ate signed		Day, Year) - 20	06
	m		30. Name and address of pers	on who co	mplet car	use of dea	th (Item 23a)	(Туре,	Print)			-		uj	.~	IW	~0	-ψ
			LILIA CEBAL		and the same of th		01 OS	LEF	R DRI	IVE	TOWS	SON	MARYL	AND	212	214		
A	Sta Registi		31. Date filed (Month, Day, Ye		2005	Hegistrar's	s Signature		And the	10								
DH	IMH 17 Rev 1/2	2001		40	2000	State State	project and									-W/25-0		

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	aryland			nt of H		d Ment		giene	UUD	120	86
	Dhuistai	¥G.	1. Decedent's Name (First, Middle, La	st)		-					ate of Dea		y Year		e of Death
	Physici /Medic		Marie	Н. В	urman						ril 1	L6,	^y 2006 ^{Year}	7:	00 P M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City	, Town, or	Location of De	eath		4c.	County of De	ath	
		П	Manor Care	7.4			lé l les els	TOWSO		Uro o o				imore	
-	Funeral Director		5. Social Security Number 6. S 212-52-1036 Usual Residence of Decedent	1 M 2 NF 7. AG	pe (In yrs. Ia: 86	Yrs.	Months		If Under 24 H	din. Ju	ate of Birth fonth, Day 1y 11	Year) 1,19	19	New You	te or Foreign
	land		10a. State 10b. County		10c. City,	Town or Loc	cation							10d. Inside	City Limits
	Mary	ţō	Maryland Baltim	nre	To	owson								101	'es 2 X No
	death with the Maryland ms 23a or 28a-f show	Directo	10e. Street and Number	01 C	1	2113011	10f. Z	p Code			1	10g. Citi	izen of What C	Country?	
	13 wit		7001 N. Charles	Street				21204	l .				U.S.	Δ	
	- dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Vas Dece Yes, sp	edent of His	spanic Origin? n. Mexican, Pu	(Specify Y	es or No-		14. Race - Am Black, Wh	encan Indian),
30	hours after turel', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 ☐ Yes 2 🛣	No	1	Yes	2[√] No	Specify:				Specify:		
	ture!		15. Decedent's E	Year or Dates:		16a. Deced	lant's He	In Conven	tion			10h K	ind of Busines	White	
Ċ	within 72 ene. than "na hedic	Completed	(Specify only highest gra	ade completed)		(Give I	kind of w		uring most of	working		100. K	ind of Busines	s/industry	
7 7	r tha	E o	Elementary/Secondary (0-12)	College (1-4or	5+)		Но	memak	er				Own I	Home	
and	be filed within 72 hours after death with the Marylar tial Hygiene. Ad other than "naturel", or tiems 23a or 28a-f show event, the Medical Examinar medical to notified at	Bec	17. Father's Name (First, Middle, Last,)					18. Mother's I	Name (Firs	t, Middle, i	Maiden		IOIIIC .	
=		ToE	Adolph D	inafelder					E1	eanor		На	nsen		
Mar	and la ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Addres	s (Street a	nd Number or	r Rural Rou	te Number	r, City o	r Town, State,	Zip Code)	
	9 £ 12 5		Judy Moran	Daughter					e Cour				Maryla		
9	1 of H		20a. Method of Disposition 1 Delia 2 Toremation 3	Removal from State	20b. Pla	ce of Dispos netery, crem	sition (Na natory or	ime of other place	9)	Date		20c. Lo	cation - City o	r Town, State	
altimol	t. Par ntmen ntant:		4 □ Donation 5 □ Other (Specif	**	Hill				rp.: 4-				wson	Mary	
ต ก	permit. Pages 1 an Department of Heal Important: If Item 2 any njury or other once.		21. Signal in of Funeral Sayvice Licer	nsee					s of Facility				Funeral		Inc.
			23a. Part1. Enter the disease, or com	nlications that cause	the death			York					land 2	21204	mata
	, <u>, , ,</u> ,		shock, or heart failure. List only Immediate Cause (Final	one cause on each I	ne.									Approxim Interval Onset a	Belween nd Death
	Physician /Medical		disease or condition resulting in death)	a. CERO Due to (or as	=13K	CVA	156	UL	410	14/	1011	130	2515		
	Examiner		1	Man (dras		ROK	16							ye	245
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as			· Com								
	cuted nd ransi	Examiner	that initiated events	c											
Š	ie exe sian a urial-i		resulting in death) Last	Due to (or as	a conseque	nce of):									
9/8 8/90	cate be executed physician and the burial-transit	dicai	•	d								-			
XO	w requires that the death certificate be execut been signed by the attending physician and should be detached for use as the burial-tran	/Me	IF FEMALE:	23c. If yes, outcome	of pregnance	· · · · · · · · · · · · · · · · · · ·									
o n	atten for u	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal d	eath 3 🗌	Ectopic p	regnancy				2	23d. Date of de Month	olivery Day	Year
		ysi	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown		30	011101 (3	paciny/							
Γ	law requires that the as been signed by th	by Pr	Part II. Other significant conditions of	contributing to death b	ut not result	ing in the un	derlying	cause give	n in Part I.	2	3e. Did tob	bacco u	se contribute	to the cause	of death?
Records	quire an sig uld bu	ed b									1 🗌 Ye	es 2	□No 3□F	robably 4	Unknown
် လ	aw re	piet								2	4a. Wasa		24b. Were a	utopsy findin	gs available
r	Inelaw ate has b page 2 s	Completed									autops perform Yes 2		death?	completion of s	of cause of
Nital Vital	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?						26. Place of D						
5	rnystcian: rthis certific ral director.	ဥ	1 ☐ Yes 2 No	Hospital: 1 Inpatie		R/Outpatient	3 D	OA Othe	Nursing	g Home 5	Reside	ence 6	6 □Other (Sp	ecify)	
	where the contract of the cont	ë.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury		28c. Injury Work		28d. D	escribe ho	ow injury	y occurred		
200	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b				М		es 2⊡No						
	or Anafter of Direction by	Certification;	4 Homicide determined	289. Place of Inj	ury - At hom c. <i>(Specify)</i>	e, farm, stre	et, factor	y, office		28f. Lo	cation (St ity or Towr	reet and n. State,	d Number or P)	lural Route N	umber,
-	To the Hospitel or Attending Fra within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier Certifying Pr	ysician: To the best	of my knowle	edge, death	occurred	at the time	e, date and pla	ace, and di	e to the ca	ause(s)	and manner a	s stated	
:	n 24 h	edical	(Check only 2 13 Medical Examone)	nysician: To the best niner: On the basis o and manner st	f examinatio ated.	n and/or inv	estigation	n, in my opi	inion, death or	ccurred at t	he time, d	ate and	place, and du	e to the caus	Θ(S)
ı	Withi To the	ž	29b. Signature and title of certifier	21,			29	c. License	number	1.0.09	2	9d. Date	e signed (Mon	th, Dey, Year	·)
	6		1///	u belie	m		4	()-00	11282	49		4	-17-0	26	
	v		30. Name and address of person who	completed cause of c	leath (Item 2	За) (Туре, Р	Print)		1 2				-17-0		
	-		AH-GAILAGE		76	00	C)S	LEI	(N)	7.	DUS	ON	172	2	204
100	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	ar's Signatur	Res	Ser B								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#12, perFit 6854,4/18/06 TT

Amend item#12, perFit 6854,4/18/06 TT

Amend item#12, perFit 6854,4/18/06 TT

			1 - State Registrar	State of Marylar	îđ / Depa <i>Cer</i>	artment of F tificate of	lealth ar Death		jiene	6 12087
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give str	BERMAN	1	45 City Taylor		APRIL	- 11 2	006 1545 PM
	Examir	ier		SPITAL		4b. City, Town, o	AUST		4c. County o	TIMURE
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24			9. Birthplace (State or Foreign
	Director		-10 10 LL0L //	^{1 2□ F} 79	Yrs.	Months Days	Hours	Min. 8. Date of Birth (Month, Day 01/11/1	1927	PA PA
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ly, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sh	tor	MD BALTIMOR	E	RAN	DALLSTOW	V			1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of WI	nat Country?
	death with the Marylan ms 23a or 28a-f show must be notified at		4817 OLD COURT ROA			21:			U.S.	
5-0036	urs after al', or its	by Funeral	11. Marital Status 12 1 Never Married 2 M Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? IX Yes 20 No If Yes, Give Year or Dates:	91	Vas Decedent of H IYes, specify Cuba I□Yes 2 X No	ispanic Origin in, Mexican, F Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	Black	- American Indian, White, etc. WHITE
۲ ک	2 8 3	eted	15. Decedent's Educat (Specify only highest grade of		(Give	lent's Usual Occup	durina most o	f working	16b. Kind of Bus	iness/Industry
1212	filed within Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	BUYER	OO NOT use retired			F00	
yiand	ould be fi f Mental H varked ott vatic avar	To Be	17. Father's Name (First, Middle, Last) MENDEL			BERMAN	LE	Name (First, Middle, I		GLICKMAN
<u>8</u>	d 2 st th and th and t7 is n traun		19a. Informant's Name/Relationship (Type) RAMONA BERMAN / WI	•				or Rural Route Number P RANDALL		
ē,	s 1 and f Health itam 27 other to		20a. Method of Disposition	20b. P	Place of Dispos	sition (Name of	1			ity or Town, State
Ē		1	1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		SINAI	cong.		1/16/2006	OWINGS I	MILLS, MD
Ball	permit. Page Department of Important: if sny injury or once.		21. Signature of Faneral Service Licensee	Cather		. Name and Addres	ss of Facility	SOL LEVINS	ON & BRO	OS., INC.
ı			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the deat	h. Do not ente	900 REIS ar the mode of dyin	ERSTOV g, such as ca	VN ROAD - P	IKESVILI est,	Approximate
	Physician		Immediate Cause (Final disease or condition		homas	ular ac	udent			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq						J
		<u>.</u>	Sequentially list conditions, b	Due to (or as a conseq	uence off:					
-	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		201.00 0.7.					
, O	e exec en an		resulting in death) Last	Due to (or as a consequence	uence of):					
0/g	ficate be executed physicien and s the burial-transit	edicai	d. ,							
٥	certific ding p		IF FEMALE:	If yes, outcome of pregna	nev					
POX	death e atten	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of de	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Monti	
j.	t the c by the	hys	9 Unknown	9□ Unknown						
v.	requires thet the death certif een signed by the attending hould be detached for use a	by P	Part II. Other significant conditions contrib	outing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
coras	een s	eted						1 🗆 Ye	s 2 □ No 3	Probably 4 XUnknown
200	G 5 CI	Completed						24a. Was an autops	n 24b. We	re autopsy findings available or to completion of cause of
VII all 1	ysician: The lis cartilicate hadirector, page	ပိ	25. Was case referred to medical						1X No 1	ath?]Yes 252(No
5	/sicla s cart directo	To Be	examiner?	pital:	ER/Outpatient	3 DOA Othe		Death Check only on		(0
0	9 Ph) ler thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe ho		
VISION	endin eath. or: Aff	atlo	1 XNatural 5 Pending 2 Accident investigation	(Month, Day 18al)	Injury		r res 2 □ No			
Ž Z	To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Director: Affer this cartific completely filled in by the funeral director, to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (Sti City or Town	reet and Number , State)	or Rural Route Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier 1 A Certifying Physici (Check only one) 2 Medical Examiner	en: To the best of my kno: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	e, date and p pinion, death o	place, and due to the ca occurred at the time, da	use(s) and manr ate and place, an	er as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License		1		Month, Day, Year)
			. Oant	ms		D	0059	736	April	11,2006
	10		30. Name and address of person who comp			Print)	HOJPITI	4L (4)	4 100	11. 2006 COURT ROAD
	Sta	te	31. Date filed (Month, Day, Year)	Registrar's Signa		AE A		, , 0(000	COUT FOAD
	Registr	A	APR 1 8 2006	1300	EA.297.3	22.0				

	State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	12088
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Day Ye. 4. Facility Name (If not institution, give street and number) 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye. 4. County of Death Month, Day Ye.	13,55 PM
Funeral Director	Months Days Hours Min. (Month, Day, Year)	D(K) Birthplace (State or Foreig Country) A(X) (A \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
with the Maryland or 28s-1 show the rectilised at Director	10a. State 10b. County 10c. City, Town or Location MARFORD BLAGR	10d. Inside City Limit 1 ☐ Yes 25 N
17215-0036 with 72 hours after deeth with the Maryland ene. then "natural", or iteme 23a or 28a-1 ehow he Medical Examiner must be ricitilised at mapleted by Funeral Director	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Country? merican Indian, /hite, etc.
21215-0036 ad within 72 hours after glene. or then "natural", or if, the Medical Examilia	1 Never Married 25 Married 1 1 Yes 2 No 1 Yes 25 No Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business	र्गिर
Maryland 21215-00 12 should be filed within 72 ho n and Mental Hygiene. The marked other then "nature traumatic event, the Medical E To Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) (Give kind of work done during most of working life. DO NOT use retired) (First, Middle, Last) (Give kind of work done during most of working life. DO NOT use retired) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame)	
ire, Maryland 21215-0036 st end 2 should be filed within 72 hours after deeth with the Marylans of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be routilised at To Be Completed by Funeral Director	Palat E CALS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State State of Street and Number of Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number or Rural Route Number, City or Town, State State of Street and Number, City or Town, State State of Sta	e, Zip Code)
Baltimore, M permit. Pages 1 end 2 popertment of Health importent: if item 271 any injury or other tra	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funtar Servi Licensee 22. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Location - City 27. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility 28. Name and Address of Facility	or Town, State
Fnysician /Medical	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of e dause on each line. Immediate Cause (Final disease or condition resulting in death) Melmom A	Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to lam ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cue to (or as a consequence of): Due to (or as a consequence of):	0
the death certific the death certific y the ettending process as the death of the d	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) Month 5 Other (specify)	delivery Day Year
cords, P. w requires that we require that is been signed be should be detaileded by PP-lieted by PP-	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	
of Vital Records, hystelen: The law requires the certificate has been signed director, page 2 should be To Be Completed by	autopsy prior performed? death	
Vision Attending r death. ector: Atten by the fune	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Qinatural 5 Pending investigation 3 Suicide 6 Could not be determined	
Div	building, etc. (Specify) City or Town, State) 25a. Cartifer (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.	as stated. due to the cause(s)
To the within 2 Complete complete	29b. Signature and title of certifier 29c. License number 29d. Date signed (M. April C.	onth, Day, Year) ノム) ~ d つ。
State	30. Name an address of person who completed cause of death (Item 23a) (Type, Print) W. A. P. I. L. G. M. (67d) N. Charle S. Bell? 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	md ZI

			1 - For State Registrar	State of Maryland		artment of H		F	Reg. No	UUO	12089
	Physic	ian	1. Decedent's Name (First, Middle, Li Lillie	,				2. Date of Dea	-	y 20 Year	3. Time of Death
	/Medi	cal						April	12		8:41 a M
1	Examí	ner	4a. Facility Name (If not institution, gi Prince Georg				Location of Death			County of Deat	
	/ Funeral	_		Sex 7. Age (In yrs. In	st birthday)	If Under 1 Year	verly If Under 24 Hrs.	8. Date of Birt	h PJ	9. Birt	Georges
	Director		241-48-4172	1□ M X □ F 70	Yrs.	Months Days	Hours Min.	Mar. 16	(5, 19)	936Maqi	hplace (State or Foreign untry) nolia, N.C.
	pui		Usual Residence of Decedent 10a. State 10b. County	10c City	. Town or Lo	cotion					
	Aaryla I eho	ŏ		,		al Heig	hts				10d. Inside City Limits 1X Yes 2 □ No
	28a-	rect	10e. Street and Number			10f. Zip Code			10a. Citi	izen of What Co	
	72 hours after death with the Maryland netural', or itams 23a or 28s-1 show Jetal Examities must be notified at	Funeral Director	6900 Pepper S	treet			743		-	J.S.A.	,-
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	.]	14. Race - Ame	
36	or its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give		T⊡Yes 2 ∑ No		riodii, oto.,		Black, White	9, etc.
215-0036	hour: turai'	g pa	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 Doors	lent's Usual Occup	otion		105 10	Bla	ack
15	nin 72 n "ne Medik	plet	(Specify only highest gi Elementary/Secondary (0-12)	rade completed)	(Give	kind of work done of OO NOT use retired	during most of work ()	ing	10D. KI	ind of Business/	industry
212	d within giene. er than "	Completed	12	College (1-4or 5+)		Clerk			Gov	7. Post	Office
	should be filed within nd Mental Hygiene. marked other then imatic event, Its M.	Be	17. Father's Name (First, Middle, Las	·			18. Mother's Name				
<u></u> ∠	should Ind Men	ဥ	Nedfiel							Willia	
Maryland	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship Wanda T.Clark				and Number or Run St.Capi				
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If Item 27 is marked other than "netural", or Itams 23s or 28s-1 show or other traumatic event, the Medical Examilist must be notified at		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of	1	Date		ocation - City or	
Baltimore	0 0		1XDSurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State Har	metery, cren Mony	Mem . Pai	rk Apr.	20,06			
ati	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service Lice		22	. Name and Addres	ss of Facility Hu	int Fur	nera	al Home	<u> </u>
00	Depa impo eny ic		+ trancis is	Hune	9	08 Kenne	edy St.N	√.W.Was	sh.E	C.200	11
	*		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Do not ente	er the mode of dyin-	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
Y.	Physician // Medical		disease or condition resulting in death)	Due to (or as a consequence	try	Julust	<u>'</u>				day
	Examiner			Septic	()5/	OCE					1 day
\/	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						, hug
P	and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Deubit	us a	leer					4 months
8760,	ate be executed sysicien and he burial-transit			d. Cerebro V	61100 or):	2000 000	e la d	•			1,00
687	~ × m	Physician/Medical	``	d. (exeryov	ww	My uu	iains				.47.
Вох	death certifica ettending ph d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan					2	23d. Date of deli	very
	death	sicia	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 ☐ Fetal of dead of time of dead of the second of the s		Ectopic pregnancy Other (specify)				Month	Day Year
P.0	that the de led by the c	Phy	9 Unknown								
	signed by the det	ρ	Part II. Other significant conditions	contributing to death but not resul	ting in the ur	iderlying cause give	en in Part I.	23e. Did to		_	the cause of death?
Records,	w requir been si should	Completed								•	
Rec	The lav	ш						24a. Was a autops perfor	sv	prior to c death?	topsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical				26 Place of Dooth		med? 2 No	1 🗆 Yes	2□ No
<u> </u>		To B	examiner? 1 ☐ Yes 2 No	Hospital: 12 Inpatient 2 E	R/Outpatien	3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Ho			S □Other /Spec	ufv)
n of	ding Phys h. After this funeral di		27. Manner of Death		28b. Time of Injury	28c. Injury Work		28d. Describe h			,,
sio	Attending it death.	cati	2 Accident investigation 3 Surcide 6 Could not to	on on		M 1 🗆 1	fes 2 □No				
Division	or At after d Direct in by	Certification;	4 Homicide determined		ne, farm, stre	eet, factory, office		28f. Location (S City or Tow			ral Route Number,
	spitai		29a. Certifier Certifying P	hysicien: To the best of my know	ledge, death	occurred at the tim	ne, date and place,	and due to the c	ause(s)	and manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Medical Exa	miner: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	pinion, death occurr	ed at the time, d	late and	place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier			29c. License		2	9d. Dat	e signed (Month	•
•	0		1 Jun	7	20-) 7		1521		4	-/14/01	
	9		30. Name and address of person who	ACH M.D 950	23a) (Type, I	SNAPOLIS	s Rd A	1 LAN	HA1	n, MD	20706
15	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	-	aske					

06-02521 Thomas Crabb

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

i nomas C	labb		I- For State Registrar	State 0	i Maryiano /		ificate of		and Men	ıaı i iygi		g. No.	006	12090
	ysicia	ın/	Decedent's Name (-			Date of Death Month pril 13, 20		Year	3. Time of Death
Medical E	xamıı	ier	Thomas 4a Facility Name (if n	James		Crabb		b. City. Tow	vn, or Location o		pril 13, 20		unty of Death	1155 hrs
				s Bayview Me				Baltimo					,	
	neral	- 1	5. Social Security Nur		7. Age	(In yrs. las	t birthday)	If Under	1 Year If Unde Days Hours	r 24Hrs. 8. Min.	Date of Birtl	h(MM/DD/\	Foreig	thplace (State or
Dire	ector	L	219-98-890	44	2 F		37 Yrs.	WOTTE	Days Flours	C	ctober	11,196		untry) Maryland
	ji i	_ L	Usual Residence of D 10a State 10	ecedent 0b. County		10c. City, T	own or Location	on .						10d Inside City Limits
pu	show a	-	Maryland :	Baltimore		D	undalk							1 Yes 2 X No
Jaryla	28a-f	~ L	10e. Street and Numb		,			10f. Zip Co	ode		10	g. Cıtizen d	of What Cou	ntry?
h the N	3a or totifie		2607 Liber						222			USA		
ath wit	or items 23a or 28a-f show any must be notified at once.	Funeral	Marital Status Never Married		12. Was Decedent Armed Forces?				of Hispanic Orig Cuban, Mexican,				Race - Ameri White, etc.	can Indian, 8lack,
îter de	r, or i		3 Widowed	4 X Divorced If		X No	1	Yes 2X	No specify:			Spec	cify: Whi	te
iours a	atura	od by	15. Decedent's Educ	cation (Specify only	highest grade com	pleted) 1			cupation (Give k		done	16b. Kind	of 8usiness/I	ndustry
36 in 72 h	han ",	Completed	Elementary/Second	dary (0-12)	College (1-4 or 5	+)				,		Dogt	aurant	
d with	other i	ĕ	12 years 17. Father's Name (Fi	irst, Middle, Last)			Co	JK.	18.Mother	s Name (Fir	st, Middle, M			
21215-0036 uld be filed within 7	rked o		Donald Cra	abb					Mar	lene F	Rita M	yers		
D 21 should	is ma	٢	19a. Informant's Name		-				(Street and Num			-		
, MD	em 27 em 27 traum		Sedley Joh		Pasto		ace of Disposi						tion - City or	nd 21222 Town State
Baltimore,	Department of realt and works registre. Important: I fitten 23 or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2		Removal from Sta		matory or oth Lawn		erv	April			alk, M	
altin	portan portan iry or	ł	4 Donation 5 21. Signature of Fune	Other Specify: eral Service License	e				ddress of Facility Y Funera					
			Anthony Colt				i 71	10 So.	llers Po	oint R	load, I	Dunda.	lk, Mo	. 21222
Phys /Me	ician dical		23a. Part I. Enter the failure. List only	one cause on each	line.							st, shock, o	or heart	Approximate Interval Between Onset and
	niner	İ	Immediate Cause (Fin or condition resulting		Hypertensiv		rosclero	tic car	rdiovascu	lar dis	ease			Death ————
			Sequentially list cond											
		nine	of any, leading to imm cause. Enter Underly	ring Cause	ie to (or as a conse	quence of):								
pa	ısıt	Examiner	(Disease or injury that events resulting in de	eath) Last Du	ie to (or as a conse	quence of):								
executed	physician and the burial - transit	ledical	X UNPENDED	T X	AMENDED ite	m#21.2	3a.PII.2	7.perFl	H,ME,G856	.6/12/0	6 TT			
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687 certifi	nding se as t	ian/	23b. Was decedent pr past 12 months?	egnant in the	1 Live birth Pregnant at	time of deat	h	al death		pregnancy		Mon	th D	Day Year
Box 68 e death certif	ned by the attending detached for use as t	Physician	1 Yes 2 No	9 Unknown	9 Unknown		5 Otr	er (Specify	"					
• =	ed by detache	by P	Part II. Other signific		ontributing to death	but not res	ulting in the ui	nderlying ca	ause given in Pa	rt I				the cause of death?
S, F	en sign	fed	<u>Diabetes m</u>	ellitus						-	24a Was a			topsy findings available
COTC law re	has be	ompleted									autops perform	sy		completion of cause of
⊤⊪	ificate r, page	O	25. Was case referred	d to medical				26	Place of Death (Chook only	1 Yes 2	No	1 🗸 Ye	s 2 No
/ital	nis cert directo	o Be	examiner?		spital: 1 🗸 Inpatie	nt 2 E	R/Outpatient		Othor	Nursing Ho		Residence	6 Other	
of \of	After this certificate has been signed by uneral director, page 2 should be detach	\vdash_{\uparrow}	27 Manner of Death		28a. Date of Inju (Month, Day,Y	v 2	28b Time of In	jury 280	c. Injury at Work	? 28d	l. Describe h	ow injury o	ccurred	
sion trendi	. 4-	atio	1 X Natural 2 Accident	5 Pending Investigation	4			1	Yes 2					
Division of Vital Records, P.O	ours arer death. reral Director: After this certificate filled in by the funeral director, page	Certification:	3 Suicide	6 Could not be determined	28e. Place of Inj (Specify)	ury - At hon	ne, farm, stree	t, factory, of	ffice building, etc	c. 28f.	Location (Stor Town, Stor		umber or Ru	ral Route Number, City
Hospit	Funera ely fill		4 Homicide 29a Certifier (Check only 1 C	ertifying Physician	I	knowledge	e, death occurr	ed at the tir	me, date and pla	ce, and due	to the cause	e(s) and ma	nner as start	red
Division of Vital	within 24 hours after death To the Funeral Director: completely filled in by the	Medical		edical Examiner:										
-	s F 0	ž	29b. Signature and tit	le of certifier	. 12		·		icense number					nth, Day, Year)
			Cahi	ulla	VS!				D.C.M.E.			April 14	, 2006	
			Name and addressZabiullah Ali,		mpléted cause of d ant Medical Ex			n Street,	Baltimore, N	/ID 21201				
		ate	31 Date filed (Month,			's Signature		A. A						
	Regist	rar	AF	R1 8 200	D Jakoba	the Sail	Alle							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 5;00A[™] Ann Corbin 2006 April 15, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7956 Pipers Path Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 7,1953 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛣 F Min. 52 217-58-1152 Yrs. Director MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits interne 23s or 28s-f show the religion of the second secon 1 Yes 2 No Director MD. Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7956 Pipers Path 21061 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō er than "naturel", or 1 ☐ Yes 2 No Specify: Š White Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 Housing Associate Catholic Charities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h is marked (ss 1 and 2 should be of Health and Ments George Walter Blankenship Doris Gertrude Bieman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7956 Pipers Path Glen Burnie, MD. 21061 Mr. Hugh Jack Corbin / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition April 18. 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If itse
any injury or ott 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Chesapeake Cremation 2006 Stevensville, MD. 21. Signature of Juneral Service Lieso 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Avenue SW Glen Burnie, MD. 401411 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** a /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of): Examine physicien and as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medicai attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown 1 TYes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo ဥ 2 ER/Outpatient 3 DOA this s after death.
I Director: After this
of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification; or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39505 Hospital Dive Glan Burnie 6 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Jarkan 305 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	•		For S	tate of Maryland						•		egible.	10000
		•	State Registrar		Ce	rtificate	e of L	Death	-		eg. No.	700	12006
H	Physicia		1. Decedent's Name (First, Middle, Last)			CAI	1 1	C		Date of Deat	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give stree	et and number)		4b. City.	Town, or	Location of I		PRIL	4c. C	2006 County of Death	
	Examin	er		TTAL		5	SAL	TIM	ORE	Ξ	Ba1	timore	City
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign ntry)
	Director		212-42-5929 Usual Residence of Decedent	87	Yrs.				Ap	ril 29	,191	.8	MD.
	yland how		10a. State 10b. County	10c. City, T	own or L	ocation							10d. Inside City Limits
	89-f e	Funeral Director	MD. Anne Arunde	1 Brook	lyn_						- 0		1 □ Yes 2X No
	with the a or 2	Dir	10e. Street and Number 652 Douglas Street			10f. Zip						en of What Cou	ntry?
	death	eral		Was Decedent Ever in U.S. Armed Forçeş?	13.	Was Deced		ispanic Origin In, Mexican, F	n? (Specify		U.S.	1. Race - Ameri	
9	or ite	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ∐ Yes 22∰No If Yes, Give		1 Yes, spec		In, Mexican, F Specify:	Puerto Hica	an, etc.)		Black, White	
21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Id other then "natural", or Items 23a or 28e-f ehow event, the Mcdical Examiner must be notilied at	d by	3 XWidowed 4 Divorced	Year or Dates:	ISA Door	edent's Usua						Specify: Whi	
-51:	nin 72 n "nai	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)		(Giv.	e kind ol woi DO NOT us	rk done d se retired	during most o f)	f working		TOD, KIII) Of Businessyn	idustry
212	filed withi Hygiene. other then	Com	7		Home	maker						e Owner	
Maryland	be filed ntal Hygid of other event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's	s Nam <i>e (Fi</i>	irst, Middle, I	Maiden S	umame)	
ryla	s 1 and 2 should by f Health and Menta item 27 le marked other treumatic ev	ဥ	Willis Atwood Fowle 19a. Informant's Name/Relationship (Type,		19b. Mail	lina Address	(Street a			orena oute Number		O tt Town, State, Zi	p Code)
	nd 2 sulth ar 27 le		Mr. James T. Callis					reet B					,
Baltimore,	es 1 au of Hea fitem r othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Rem	20b. Plac	e of Disp	osition (Name	ne of	(a)	Date		20c. Loca	ation - City or T	own, State
iii.	it. Page rtment o ortant: If injury or		' 4 □ Donation 3 □ Other (Spicity)	Ced		ill C			ril 1 2006			oklyn,	
Ball	pernit. Pages Department of h Important: If its any njury or of		21. Signatur and Pervice Licensee	1/024									me, P.A.
			23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that caused the death.	Do not er	Secoi	.10. A. leofdyin	g, such as ca	S.W. ardiac or re	GIEN I	3urn∃ øst,	ie, MD.	Approximate
	Physician		Immediate Cause (Final disease or condition	METABOL				20212					O 2 OAYS
П	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):								CHAIR
H	LAAIIIIICI	Je.	Sequentially list conditions, if any leading to immediate	LAYPER N	nce of):								2 LA73
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ACUTE	R	ENY	JF	FA	416	IRE			02DAYS
ó	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequer				·					
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9 x	death certificate b attending physic	Physician/Med	IF FEMALE: 23c. Was decedent pregnant 23c.	If yes, outcome of pregnancy			- 1,0				23	3d. Date of deliv	erv
. Box	death e atter	lciar	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat		□Ectopic pr □ Oth <i>e</i> r (sp		'				Month	Day Year
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	8 50	by	Part II. Other significant conditions contrib ATRIAL FI	BRI LATI			ause giv	en in Paπ I.			es 2 🔀		the cause of death? bably 4 Unknown
Records,	w requir been si should	Completed	HYPERTEN							24a. Wasa	n	24b. Were aut	opsy findings available
Re	The law te has	ошр	1111011	3.0.						autops perform	med?	prior to co death? 1 ☐ Yes	ompletion of cause of
Vital		BeC	25. Was case referred to medical examiner?						of Death (C	heck only on			
of V	Physicien: r this certificatel director,	2	1 ☐ Yes 2 ▼No	1 Denpatient 2 LEH	VOutpatie			4 🗀 140/5		5 🗆 Reside		Other (Speci	fy)
on	ding h	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	M	28c. Injun Worl 1 □	k? Yes 2 □ No		. 20301100 110	SW IIIIJUTY	occurred	
Division	l or Attending after death. Director: After In by the fune	Certification:	a Could not be	28e. Place of Injury - At home building, etc. (Specify)	e, farm, s	treet, factory	, office		28f.	Location (St City or Town		Number or Rur	al Route Number,
D	irs after or rel Dir												
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical		an: To the best of my knowle On the basis of examination and manner stated.									
	To the Within To the	Me	29b. Signature and title of certifier	0		290	_	e number	2.0	2	9d. Date	signed (Month	Day, Year)
			Mob Cenum	1 teyssa	M	a,	R	ESO	000	A	PR	14	2006
	10		30. Name and address of person who comp			Print)	ST	Ωι	01-11	MORE	. ,	an :	21225
	Sta	ate	31. Date filed (Month, Day, Year)	32. pegistrar's Signatur		0	۱ د.	U	1000			(,0	
	Regist		APR 1 8 2006	Rem B	19	posite	0.						

			_	State of Ma								
		•	1 - State Registrar			Certifica	te of L	Death		Reg. No.	006	12093
	Physicia	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Sr. M. Cecelia		n, R.S.		Tournor	Location of Deal	April	13	2006 County of Death	12:30 P
	Examin		4a. Facility Name (If not institution, give	street and number)					(i)			
	Funeral		The Villa 5. Social Security Number 6. Security Nu		e (In yrs. last birti		timo r1Year Days	If Under 24 Hrs Hours Min.		th	3altimo	place (State or Foreign
	Director		220-34-8862	□ M 2 TyF	95 Y	rs.	Days	Hours Will.	5-9-1	910	Ire	land
	land		Usual Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. City, Town	or Location						10d. Inside City Limits
	Mary -1 sho	tor	MD Baltimo	re	Balti	more						1 ☐ Yes 2 ☐ No
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	n 72 hours after death with the Maryland "neturel", or Items 23a or 28e-f show polical Exacultation and be multified at	ral	6806 Bellona Av				1212	. 0::04		ця		
_	ter de Items	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 □ Yes 2√7				spanic Origin? (8 n, Mexican, Puer	Specify Yes or No to Rican, etc.)		14. Race - Ameri Black, White	, etc.
220	ours af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ If Yes, Give X Year or Dates:		1 ☐ Yes	2 No	Specify:			Specify: Wh	ite
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7	within ane. than '	ldm	Elementary/Secondary (0-12)	College (1-4or	5+)		use retired, a c h e 1			Pri	lvate S	chool
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Ian	ould be Mental Parked Patic ev		John Coleman					Mary	Buck			
Mary	2 sho and h Is ma		19a. Informant's Name/Relationship (7	D = 1 -1	10118	•	-	ınd Number or R	ural Route Numb	-		
	s 1 and f Health item 27 other tr		Sisters of Merc	y-Reils	113	00 E .	Nort	hern P	arkway Date		11to.,	MD 21239
5	ages nt of h :: If ite		X Burial 2 ☐ Cremation 3 ☐			Disposition (Na y, crematory or		1			•	
Baltimore,	artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Lice)	500	Woodl	awn Ce	mete ind Addres	s of Facility Dr	9-06	Bal Aabt	timore	, Marylan eral Home
ñ	permit. Departm Importa any inju		Thatak			PA. 2	2134	Willow	Sprin	g Rd	.on run l 212	22
T			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	d the death. Do n	ot enter the mo	de of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		hnonic				<			Onset and Death
	/Medical Examiner		resulting in death)		a consequence o							c v t
	4	ē	Sequentially list conditions, if any, leading to immediate	D	a consequence of	of):	2					3 (0,0
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Errier understand Cause (Disease or injury that initiated events		a consequence of	ve .	heari	t fo	alung			10 Yr=+
Ď,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence o							
8/60	ys te	dical		d							-	
X 68	The law requires that the death certificate the has been signed by the attending phy oage 2 should be detached for use as the	by Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy		ne com	- 100			23d. Date of deliv	verv
ROX	death a atten	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death	3 □Ectopic ; 5 □ Other (s					Month	Day Year
J.	at the de by the tached	hys	9 Unknown	9□ Unknown								
	res thai signed i be det	by F	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the underlying	cause give	en in Part I.			_	the cause of death?
Records,	w require been sig should b	eted								Yes 2	_	bably 4 Unknown
ခိုင	ne law has t ge 2 s	Completed							24a. Was auto perfo		prior to co death?	opsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical					26 Place of De	1 ☐ Yes		1 🗆 Yes	2 - No
	ysicie s cert direct	OB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ER/Out	tpatient 3 C	Othe		Home 5 ☐ Resi		5 □Other (Speci	fy)
ō	ng Phys fter this neral di	J: T	27, Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. T	ime of	28c. Injury Work	at	28d. Describe	how injur	y occurred	
Sio	Attendia death. ctor: Al	catle	2 Accident investigation 3 Suicide 6 Could not be			М		res 2 □ No	006 Lanation (·C44	d Months and Dec	at Davida Miranhaa
Division of	of or Attending Fatter death. I Director: After the in by the funeral.	Certification:	4 ☐ Homicide determined	200. Flace 01 III	jury - At home, far tc. <i>(Specify)</i>	rm, street, facto	ry, office		City or To			al Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			ysician: To the best								
	he Ho in 24 i	edical	(Check only 2 Medical Exan	niner: On the basis of and manner st	of examination and ated.				urred at the time,			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	K.3.			9c. License	number 3 / FC J		29d. Dat	e signed (Month,	
	^		man -		100 th (100 0 230)			, , , , ,			4/13/	06
	D		30. Name and address of person who	SZ/ N	Gutan (Hem 23a) (v street	_ /	Bootin	ae 7	nd	2120	1
	Sta	te	31. Date filed (Month, Day, Year) APR 1 8 21	32/Regist	Gutan rar's Signature	Anaski	,					
	Regist	ar	HLK T 8 71	UUO A A	and the f	No. of Street, or other Parks						

			for State Registrar	State of Ma	ryland				lealth a Death	and M	ental F	lygier Reg.	$Z \cup U$	6	120	194
-26	Physici	an	1. Decedent's Name (First, Middle, Las	1)							2. Date of Month		Day	Year		of Death
	/Medic	cal	Marcia Colette I		swell		45 035	Taura		4 D 4 b	Apri1		2006 4c. County		9:	10A M
*	Examir	er	4a. Facility Name (If not institution, give	,					Location o	or Death						
• <u>;</u> }	Funeral	%; *	4306 Prince Road 5. Social Security Number 6. Se	7. Age	(In yrs. la	st birthday)	If Unde	cvill r1Year	If Under		8. Date of (Month,		Monte	9. Birth	olace (State	or Foreign
***	Director		5/7-48-6343	☐M 2 X F	68	Yrs.	Months	Days	Hours	Min.	May 1			Pen	nsy1v	ania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	. Town or Lo	cation							1	10d. Inside	City Limits
	Maryi f eho	ō	Maryland Montgome	rv	Rock	ville										s 2 XNo
	r 28a	Director	10e. Street and Number	. Ly	NOCI	CVIIIC	10f. Zi	p Code				10g.	Citizen of V	What Cou	ntry?	
	th with		4306 Prince Road				20	0853				Un	ited	Stat	es	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Items 23s or 28s-f show any highry or other traumatic event, the Medical Eraclinational temperature and once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	ver in U.S	1	Was Dece f Yes, spe I ☐ Yes	ecify Cuba	ispanic Origin, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or Rican, etc.)	No-		ck, White,		
Ö	2 hou	ted	15. Decedent's Ed	ucation		16a. Deced	lent's Usu	ial Occupa	ation			16b	. Kind of Bu	Wh:		
215	thin 7.	pie	(Specify only highest grad	de completed) College (1-4or 5+)	(Give life. L	KIND OF WI DO NOT I	ork done d ise retired	during most ()	t of worki	ng					
5	ygien ygien yer th	Completed		5+		Art	ist						elf-E		yed	
and	be fill hall H bd off	Be	17. Father's Name (First, Middle, Last)								(First, Mide		ien Suman	7e)		
$\frac{8}{5}$	hould d Mer marke matic	ပ္	Michael A. Bartk			19h Mailin	o Addres	s (Street :			hansk <i>I R</i> oute <i>Nut</i>		by or Town	State Zir	Codel	
ltimore, Maryland 21215-0036	Ith an 27 is r trau		Clayton M. Creswe				_									21035
re,	s 1 ar		20a. Method of Disposition		20b. Pla	ace of Disno	sition /Na	me of			17,		Location -			21033
Ē	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☒ Other (Specify	Removal from State Entombment		metery, create of		n		2006	1/9	Si	1ver	Spri	ne. M	aryland
Balti	permit. Departn Imports any Injk		21. Signature Ineral Service Library	eu.		0803 R	. Name a	nd Addres Llle, Llle,	is of Facility Inc. Mary	y Rob 30 1and	ert A 0 Wes 208	. Pu	mphre	y Fu lery	neral Avenu	Home/
*)			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	lications that caused to one cause on each line	he death.	. Do not ente	er the mo	de of dyin	g, such as	cardiac o	r respirator	arrest,			Approximation Interval Bio	etween
1	Physician		Immediate Cause (Final disease or condition resulting in death)	aEndome	tria	1 Can	cer								18 Mo	
	/Medical Examiner		1 Country	Due to (or as a	consequ	ence of):										
l so	7	er	Sequentially list conditions, if any, backing to immediate cause. Enter Underlying Cause (Disease or injury	b. Cus to (or as a	euneuqu	ariou ofly:										
	cate be executed oblysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c												
o	e exection ar	Ex	resulting in death) Last	Due to (or as a	consequ	ence of):										
8760,	ate by thysici the bu	dicai		d												
9	Jeath certifica attending ph of for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome o	f pregnan	ncy							23d Dat	te of delive	20/	
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1□Live birth 2 4□Pregnant at ti			Ectopic p Other (s	regnancy pecify)				-	Mo		Day	Year
P.O.	t the by the tache	hys	9 Unknown	9□ Unknown												
rds, F	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions or	ntnbuting to death but	not resul	lting in the ur	nderlying	cause give	en in Part I.						he cause of pably 4	
Division of Vital Records,		Completed								,		topsy rformed:	? 5		psy finding mpletion of 2 No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	(Jassita).				104			(Check on					
of	Physical direction	<u>۲</u>	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien		R/Outpatien 28b. Time of		OA DUIN	4 Nu		ne 5 🔀 Re				(y)	
O	ding Phy h. After thi funeral	tion	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Injury	м	28c. Injury Work 1 □ `	rai (? Yes 2 □ î		OU. Descrit	ie now in	ijury occuri	90		
Nisi	i or Attending Physician: after death. Director; After this certifice I in by the funeral director, I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur	y - At hor (Specify)	me, farm, stro					28f. Location City or	(Street Town, St	and Numb	er or Rura	al Route Nu	mber,
Ω	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director; completely filled in by the		29a. Certifier 1 To Certifying Phy	sician: To the best of	my know	vledge, death	occurrec	at the tim	ne, date and	d place, a	and due to the	ne cause	(s) and ma	nner as s	taled.	
	in 24 h	edicai	(Check only 2 Medicat Exam	iner: On the basis of e and manner state	examinati	on and/or inv	estigation	n, in my op	oinion, deat	th occurre	d at the tim	e, date a	and place, a	and due to	the cause	(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	160000	1 11	Δ	29	c. License	e number			29d. I	Date signed	d (Month,	Day, Year)	
•				Haggert				D32	407			Apı	ril l	4, 20	006	
	10		30. Name and address of person who of Joseph M. Hagger			23a) (Type, Medic		ente	r Dri	ve	Rocky	i11a	Mar	v1an	1 209	850
14	Sta		31. Date filed (Month, Day, Year)	37 Registrar						, ,	LOCKY		, mar	<i>y</i> = am	. 200	
	Registr	ar	APR 1 8 20	36 Maries	· ST.	STATE										

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Amend item#5.perFH.0855.5/4/06 TT.

			Amend item#5,j 1 - For State Registrar	perra (State of	Marylan			of Health of Death			giene Reg. No.	006	12095
*	Mary 1		Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death
gri	Physici		Martha H. Cox							Month April	14.		1343 ^M
	/Medio Examir		4a. Facility Name (If not institution, g	give street and numb	per)		4b. City, Tov	vn, or Location	of Death		1	County of Dea	
			Suburban Hospi	tal			Beth	iesda			M	lontgon	nerv
	Funeral			Sex 7	Age (In yrs.	last birthday)	If Under 1 Y		r 24 Hrs. Min.	8. Date of Birt (Month, Da	th	9. Bi	rthplace (State or Foreign
	Director		1/7- 42-1660	1□M 2XF	10	2 Yrs.	Widness D	uys Hours		Mar. 2	9, 1	904 St	witzerland
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	cation						10d. Inside City Limits
	• ho	5											1 X Yes 2 □ No
	28a-1	Director	Maryland Montgo	omery	Ken	singto	10f. Zip Co	do			10a Citia	zen of What C	Countral?
	with												-
	hours after death with the Maryland tural', or Items 23a or 28s-f show al Examinar must be notified at	Funerai	4115 Everett St	reet 12. Was Deced	ent Ever in U.	S. 13.	208 Was Decedent		rigin? (Sp	ecify Yes or No		ed Sta	encan Indian.
	fter d	교	1 ☐ Never Married 2 ☐ Married	Armed Force	es?		f Yes, specify	Cuban, Mexica	an, Puerto	Rican, etc.)		Black, Wh	
ĕ	urs a	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2🎇	No Specify	<i>/</i> :			Specify:	White
Ō	2 ho	Completed	15. Decedent's	Education			dent's Usual O		at adade		16b. Kir	nd of Busines:	
2	thin 7	pie	(Specify only highest (Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT use re	one during mo. etired)	St OF WORK	ing			
2	or th	5	12			F	Realtor	. ,			R	Real Es	tate
D	d oth	Be	17. Father's Name (First, Middle, La	ist)				18. Moth	ner's Name	e (First, Middle,	Maiden .	Sumame)	
<u> </u>	Men Men arke	မ	Ernst Hegg					Ma	argue	rite E	icher		
ā	and la m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (St	reet and Numb	oer or Rura	al Route Numbe	er, City or	Town, State,	Zip Code)
<u>~</u>	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, The Medical Examiliar must be notified at		Janet Griffith/	Daughter_	Took D								nd 20895
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	Removal from St	0	emetery, crer	sition (Name of natory or other		April	19.	20c. Loc	cation - City o	r Town, State
<u>Ħ</u>	permit. Pages 'Department of H Important: If its eny injury or ot		4 □ Donation 5 □ Other (Spe	A.	Cr	ntgome: emator	ium, In	c	2006_		Beth	esda,	Maryland
Baltimore, Maryland 21215-0036	Depariment Department Tempor		21. Signatura Funeral Service Lic	cens-e		B	2. Name and A ethesda	ddress of Facil I–Chevv	ity Rot Chas	ert A. se. Inc.	Pump 75	hrey F	uneral Home/ consin Avenu
	00300		Calcale	· serry	- M008	$803 \mid B$	ethesda	, Mary	land	20814-	<u>-3501</u>		
ı			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau ity one cause on eac	ised the death th line.	h. Do not ent	er the mode of	dying, such as	s cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
11	Physician		Immediate Cause (Final disease or condition	_a_Ather	oscler	otic C	ardiova	ascular	Dis	ease			Years
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):							
70		_	Sequentially list conditions,	b. Door to to	às à consequ	and the same							
	ped ssit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	553 (5)	as a consequ	uanca or,							
	and and	хаг	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):			-				
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	a E			·								
687	icate phys s the	dicai		d.									
	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy					2	3d. Date of de	discon
Box	atter atter	ciar	in the past 12 months?		h 2 ☐ Feta nt at time of de		Ectopic pregn Other (specifi					Month	Day Year
P. O.		ıysi	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unknow			(-,)	,,					
			Part II. Other significant conditions	s contributing to dea	th but not resi	ulting in the u	nderlying cause	e given in Part	1.	23e. Did to	obacco us	se contribute t	o the cause of death?
rds,	requires een sign rould be	d by	Renal Failure							10	res 2🛚	JNo 3□P	robably 4 Unknown
S	> 0 0	Completed	Pneumonia							24a. Was	an	24b Were a	utopsy findings available
Re	0 L B	щ	THEGINOTITA							autop perfo	rmed? 2 No	prior to death?	completion of cause of
æ	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					OC Diag	o of Dooth	1 ☐ Yes		1 ∐ Ye	s 2□ No
>		To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Titor	patient 2 🗆	EB/Outnation	t 3□ DOA			me 5 ☐ Resid		□Other (See	20(6)
Division of Vital Record			27. Manner of Death	28a. Date of	Injury	28b. Time of		Injury at Work?		28d Describe I			эспу)
0	Attending I r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury		Work? 1 Yes 2]No				
VIS.	or Attendation after death Director: in by the	if Cé	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of	Injury - At ho	ome, farm, str	eet, factory, off	fice				Number or F	lural Route Number,
á	al or s afte if Dire	Certification;	4 Homicide	building	, etc. <i>(Specil</i>)	Y)				City or Tov	vn, State)		
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 💥 Certifying	Physician: To the b	est of my kno	wledge, death	occurred at th	ne time, date ai	nd place,	and due to the	cause(s)	and manner a	s stated.
	ne Hd n 24 ne Fu	edicai	(Check only 2 Medical Ex	aminer: On the bas and manne	is of examination of stated.	tion and/or in	vestigation, in r	my opinion, dea	ath occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To the within 2. To the complet	M	29b. Signature and title of certifier				29c. Lic	cense number			29d. Date	signed (Mon	th, Day, Year)
)			P. Zeen	an, MD			D3	6552			Apri	1 17,	2006
	in		30. Name and address of person wh			1 23a) (Type,	Print)						
	17		Pankaj Talwar,					ve #401	, Ro	ckville	, MD	20852	2
.a.	Sta		31. Date filed (Month, Day, Year) APR 1 8	2005 32. Reg	jistrar's Signa	ituse,	CAR D						
	Registr	ar	HLU T 9	2000	Sellen de	Marie Charles	Hard Town						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20c, perf 1,035/4/18/06 TT / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** sam u 6:20PM 2006 /Medical 4c. County of Peath 4b. City, Town, or Location of Death 4a. Fability Name (If not institution, give street and number) Examiner the STOWN timor OY Ta 0 24 Hrs. 8. Date of Birth Min. (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7 Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Days Hours Yrs. 218-01-4853 87 02/15/1919 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County th and Mental Hygiene. ?? is marked other than "natural", or Iteme 23a or 28e-f show traumatic event, the Madical Examilier roual be notified at MD BALTIMORE 1 ☐ Yes 2 No BALTIMORE Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 SLADE AVENUE # 419 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PHARMACIST PHARMACY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be file Deperment of Health and Mental Hy Importent: If Item 27 is marked oth any lighty or other traumatic event 908.8. Be COHEN **KOLTOFF** ABE I DA LEAH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNICE H. COHEN / WIFE 7 SLADE AVENUE #419 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Baltimore 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 04/17/2006 REISTERSTOWN, Juneral Service Acensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign 3/2 Maria 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carse on each line. Immediate Cause (Final Physician days disease or condition resulting in death) ommunity /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the deeth certificate be executed ending physicien and use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by s been signer 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 2 No 1 Yes Subacute director, Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 ☐ Yes 2 🗷 No unit this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.
To the Funerel Director: A completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Hospital Certifying Physician: To the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature le of certifier 29c. License number and 62912 Hospitalist 2006 0 '0α a 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2006 Registrar

			For State Registrar	State of Maryla		artment of <i>tificate of</i>			Reg. No.	6 12097
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Y	3. Time of Death
	/Medio	al	Hilda G. 4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of Deat	April	17, 2006 4c. County of	
	LAGITIII	CI	Chapel Hill Nursi			Randal	1stown		Balt	imore
ı	Funeral Director		5. Social Security Number 6. Sex 215−14−9291	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Yea Months Day		(Month, Da	th y, Year) 9 3, 1923	Birthplace (State or Foreign Country) Maryland
	ס		Usual Residence of Decedent					Julie 1	J, 1725	Haryland
	anylan show	پ	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	Director	MD Baltime	ore	Phoenix	10f. Zip Code			10a Chinas of Wh	
	with the or i	Dir	14226 Phoenix Roa	a d					10g. Citizen of What	at Country?
	death with the Maryland ime 23a or 28e-f ehow futual by notified at	Funeral		2. Was Decedent Ever in	U.S. 13.		21131 Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No		American Indian,
2-0030	permit. Peges t and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28e-1 ehow any Injury or other traumatic event, the Madical Examinat must be notified at an	þ	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		TYes, specify Cu 1 ☐ Yes 2 💢 N		to Alcan, etc.)		White, etc. White
ה ה	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occ	upation e during most of wo	rking	16b. Kind of Busin	ness/industry
7	Aithin ne.	mpi	Efementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retii	red)	J	Black &	Decker
7 0	Hygie theri	e Co	6 17. Father's Name (First, Middle, Last)	N/A	Asse	шоту тт	ne person	me (First, Middle,	, Maiden Sumame)	DOURCE
yland	lid be ked o	To Be	Sherman O. Schaffe	er			Leolu	Viola M	iller	
Mary	and N		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru	ural Route Numbe	er, City or Town, Sta	ate, Zip Code)
e, G	and and mark		Benjamin R. Dorn/S		1503	Sunders	Way Gler		, Marylan	
E	ages t nt of H :: ff Ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery crent t. Johns hurch	natory or other p. S Luther	an Apri	L1 21,	20c. Location - Ci	
Saltin	nit. Po artme ortani Injury		4 □Donation 5 □Other (Specify) 21. Signature of Funeral S (rvice scense)		22	. Name and Add	ress of Facility		Westmins	
ñ	Depa Impo any l) De la	Michael J. F	lagle	Lemmon H 10 W. Pa	Tuneral Ho Idonia Roa	ome of Du ad Timon	ulaney Va ium, MD 2	11ey, Inc. 1093
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the de e cause on each line.						Approximate fnterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	13/5/F	نعت	21)1	2000	2		Oriset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):				0001	
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09/99	= O 6	D	- 0		,, <u> </u>		*			
X Q Q	death certifi e ettending id for use as	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?	3c. If yes, outcome of prec 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnan	icy		23d. Date of	,
5	0 0	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time o 9⊡Unknown	death 5	Other (specify)			Worth	Day Teal
7.	The law requires that the de Ne hes been signed by the v bege 2 should be detached	y Physi	Part If. Other significant conditions con	tributing to death but not r	resulting in the u	nderlying cause (given in Part I.	23e. Did t	obacco use contribu	ute to the cause of death?
ecords,	quires an sign	ed by	ESSENTIO	5/71	rado	OILM	0	10	Yes 2 40 3	☐ Probably 4 ☐ Unknown
000	law re es be 2 sho	Completed	Ofteaul	المل				24a. Was		re autopsy findings available or to completion of cause of
VII A		Con	DStropus	20515				perfo	ormed? dea	ath?]Yes 2□ No
VII	iding Physician: th. : After this certifice funeral director, p	Be	25. Was case referred to medical examiner?	ospitaf:				ath (Check only o		
ō	A id o	. To	1 Yes 2 No	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year,		IT 3 DOA	4 Simulating P		dence 6 Other	
0	ath. or: Afte	atlo	1 ☐Natural 5 ☐ Pending investigation	(Month, Day Year,) fnjury		ork? ☐Yes 2☐No			
DIVISION	at or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, larm, str ecify)	eet, lactory, offic	9	281. Location (City or To	Street and Number wn, State)	or Rural Route Number,
	ne Hospitat or Attending P n 24 hours after death. Ne Funeral Director: After t sietely filled in by the funera	ledical (29a. Certifier U Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my ler: On the basis of exam and manner stated.	rnowledge, death ination and/or in	h occurred at the vestigation, in my	time, date and place opinion, death occi-	e, and due to the urred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To the within 2. To the complet	Ž	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Month, Dey, Year)
			Vall V	homel	M	10	1475	3	114	8106
1			30. Name and address of person who con						,	
	Sta	ite	Robert B. Kroopni 31. Date liled (Month, Day, Year)	ck, M.D. 40 32. Registrar's Sig	gnature		ad, Suite	300, P	ikesville	, M D. 21208
	Registr		ADD 1 0 20		Ro A	Sand 0				

Please Type or Print in Black Indelible Ink Rodney Antonio Diggs State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First Middle, Last) Rochey Antonio Diggs 2. Date of Death Physician/ Month 1947 hrs **Medical Examiner** April 12, 2006 4b. City, Town, or Location of Death c. County of Death not institution, give street and number 7022 Parks Height Avenue **Baltimore** 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. 8irthplace (State or 7. Age (In vrs. last birthday **Funeral** Director 218-60-5627 Country) Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Yes 2 28a-f show more should be filed within 72 hours after death with the Maryland and Mental Hygiene. notified at once, rector 10e Street and Number 10g. Citizen of What Country Funeral Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, 8lack "natural", or items Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Yes Yes 2 No specify Divorced If Yes, Give Year 3 Widowed 4 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ont of Health and Mental Hygiene.

If item 27 is marked other than "other traumatic event, the Medical I Baltimore, MD 21215-0036 101 18 Mother's Name (First, Mide Be ဂ္ Pages 1 and 2 20b. Place of Disposition (Nam Cremation 3 2 Burial Removal from State Important: injury or oth Other Specify Fineral Serv m 21133 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as Approximate Interval cardiac or respiratory arrest, shock, or hear **Physician** st only one cause on each line. Hypertensive atherosclerotic cardiovascular disease Between Onset and /Medical Death Narcotic intexication Immediate Cause (Final disease Sxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical XAMENDED item#1,23a,27,28a-f,perME,0855,5/24/06 TT item#23a,PTI,27,28a-f,perME,e857,7/17/06 TT XUNPENDED ysician a burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy phy the 23d Date of delivery 3b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Fetal death Month Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş Diabetes Mellitus Yes 2 No 3 Probably 4 ✔ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? certificate page 2 No Yes 2 V No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other Scene DOA this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 X Natural death. Find 4/12/2006 To the Funeral Director: FNd 7:30 FM unk Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc (Specify) Found at residence Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) OCME April 14, 2006 a 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Year)

			State of Marylan		rtment of H			ZUU	6 12099
E	Physicia		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)	D	isney	15R	2. Date of Dea Month	Day	Year 3. Time of Death
>	/Medic Examin		4a. FAcility Name (If not institution, give street and number) DALHIMORE VAMEDICAL	Carter	BAL	Location of Deal	'e	4c. County	W U U
	Funeral Director		5. Social Security Number 214-26-3963 Usual Residence of Decedent	/ast birthday)_ Yrs.	Months Days	If Under 24 Hrs Hours Min		933	Birthplace (State or Foreign Country) MD
	aryland show	-	10a. State 10b. County 10c. Cit	ty, Town or Loc	ation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	Irecto	MD Anne Arundel Se	evern	10f. Zip Code			10g. Citizen of W	
	23a o	aiD	8301 Grainfield Road		21144	+		USA	
336	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaluirar must be rediffied at ODGs.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4¾ Divorced 12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	Jf	/as Decedent of Hi Yes, specify Cuba ☐ Yes 2K No	ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		e-American Indian, k, White, etc. white
Maryland 21215-0036	ithin 72 hore.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give k life. D	ent's Usual Occupa ind of work done of O NOT use retired	during most of wo	orking	16b. Kind of Bu	
7	iled wi tygien her th		12 17. Father's Name (First, Middle, Last)	Drywa	all Contr		me (First, Middle,	Constru	
/lanc	Mental H	To Be	Henry C. Disney				et Ann Jo		-
Man	nd 2 sho lth and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print) Mrs. Loretta M. Willis /daughte				Rural Route Numbe		
Baltimore,	ges 1 ar it of Hee if item or other		20a. Method of Disposition 20b. F 20b. F 20b. F 20c. F 2	Place of Dispos cemetery, crem	ition (Name of atory or other plac	9)	Date	20c. Location -	City or Town, State
턡	it. Pa ntmen ntent: injury		4 Donation 5 Other (Specify) Me				5-2006		e, MD Home, PA
ä	Dep Impo		m01459				Glen Burr		,
	Physician		23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	th. Do not ente		g, such as cardia	ac or respiratory ar	rest,	Approximate Interval Between Onset and Death I month
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Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours effer death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page	ation: To	1 Yes 2 Monner of Death 1 Manner of Death 1 Matural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injun	4 🗀 Nursing	Home 5 Resid	lence 6 ∏Othe low injury occurre	******
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	To ti Withii To ti comp	Ž	29b. Signature and title of certifier	h	29c. Licens			-	(Month, Day, Year)
,	6		30. Name and address of person who completed cause of death (Iter	m 23a) (Type F	YY P/4	TE		4/Kil	11.000
	1		Meliger K. MARTIN N	10 10	NGRE	LENE S	treet	BALTI	11.2006 nuleMJ2D01
	Sta Registr		31. Date filed (Month, Day, Year) 32. Solstrar's Signal APR 1 8 2006	M. La	ask)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:10 P M 4-12-2006 Anna E. Diffendal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severna Park Nursing Center Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Sociaf Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F 76 1-25-1930 216-30-1529 MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinal must be neutified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Anne Arundel Brooklyn Direct 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 21225 616 Lorca Avenue U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2000No white Specify Specify þ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Yingling 2 Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Marshall Radford / son 806 Oakdale Circle; Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Glen Haven Mem. Park 4-20-2006 Glen Burnie, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home PA Maj3571 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Etter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate fnterval Between Immediate Cause (Finaf disease or condition resulting in death) Onset and Death epsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical fF FEMALE: 23c. ff yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mounts? Month 4 Pregnant at time of death 5 Other (specify) the the detached 9□ Unknown 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause/given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed þ 90 47 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy certificate 1□ Yes 2 Be (director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Inpatient 2 1 Yes 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t 1 Natural Injury 5 Pending 1 🗌 Yes 2 □No investigation 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 29b. Signature and title of certifue 29c. License number 29d. Date signed (Month, Day, Year, 50725

Registrar
DHMH 17 Rev 1/2001

State

lenniter

31. Date filed (Month, Day,

860

32. Paistrar's Signature

30. Name and address of person to completed cause of death (Item 23a) (Type, Print)

Year)

terans Huy Millers ville MD2110

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 14, APRIL ²⁰⁰⁶ DREYER SELMA 9:00 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/17/1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 □ F Yrs. 217-34-3729 89 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or Items 23a or 28a-f show The Medical Examiner must be notified at MD BALTIMORE BALTIMORE 1 Yes 2 No Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 OLD MILFORD MILL ROAD 21208 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ WHITE 3 X Widowed 4 ☐ Divorced il Hygiene. other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental SAPPERSTEIN LEVIN LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10393 N. 135th WAY - SCOTTSDALE, AZ. 85259 ELLEN GUSS / DAUGHTER t of Heelth a if Item 27 is or other tra Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. BETH JACOB CONG. 04/16/2006 FINKSBURG, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pari1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi co, or heart vailure. List only one cause on each line. Immedia e Cause Final disease or condition ZHEIM Friysician resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physicien and the burial-transit resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical ettending physi-I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 5 Other (specify) 4☐Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed certificate 2 T.NO 1 ☐ Yes 2 / No 1 ☐ Yes of Vital or Attending Physicien: After this certification, funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes Medical Certification: To 2 740 A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manual of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending ours after death. sral Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funsral (
completely filled Hospital To contrying Physician: To the bart of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintur ac stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14/06 suce 30. Name and address of person who completed cause of death (Item 23a) (Type 1 7220 31. Date filed (Month, Day, 32. Aégistrar's Signature State Registrar

06-02510 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene John A. Empry 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 2100 hrs John Albert Emory Medical Examiner April 12, 2006 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Bivalve Wicdmicd Cedar Hill Marina 9 Birthplace (State or Foreign North If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs last birthday) **Funeral** Months Days Hours Min Director Oct 3, 1933 242-52-9768 72 1 X M 2 Country) Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Ě 1 Yes 2 XNo 28a-f show Erie East Aurora New York hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? notified at 14052 3050 Three Rod Road items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2 X No f Yes. Give Year Specify: White Widowed Divorced Yes 2 X No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Medical Exduring most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quality Control Engineer 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Currence John Austin Emory 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3050 Three Rod Road East Aurora, New York 14052 Lois R. Emory, Wife 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 04/14/06 Baltimore, Maryland Metro Crematory Inc. Donation 5 Other Specify 21. Signature of Funeral Service Licensee Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary Thomas Gregor Marvland 21228 23a. Part I. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, stal or Attending Physician: The law requires that the death certificate by 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy phy the 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 s death? performed? Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25 Was case referred to medical Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene After this 1 V Yes ဥ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury Certification: 1 🗸 Natural 5 Pending 1 Yes 2 No 24 hours after death Funeral Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the one) and manner stated 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 13, 2006 se of death (Item 23a) Name and address of person who completed car Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, Day Year,

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink

nn Francis Elir		State of Maryland / Depar	rtment of F		Mental I		201	16 12103
Physicia		Decedent's Name (First, Middle,Last)				2. Date of Dea		3 Time of Death
edical Exami	ner	John Francis Eline				Month April 12, 2	Day Year 2006	1312 hrs
		4a Facility Name (if not institution, give street and number)		City, Town, or L	ocation of Dea		4c. County of	Death
		Patapsco River near 4601 Newgate Aven		Baltimore				more City
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24	and the second	th(MM/DD/YYYY	Birthplace (State or Foreign
Director		212-30-5540 X M 2 F 73	Yrs.	World's Days	Hours M	2-12-1	.933	Country) MD
è		Usual Residence of Decedent 10a. State 10b. County 10c. City T						
ow any			Town or Location					10d Inside City Limits
yland I-f sh	ģ	MD Anne Arundel Broo						1 Yes 2 X No
e Mar or 28;	ĕ		1	0f. Zip Code		1	0g Citizen of Wha	at Country?
ith the Maryland 5 23a or 28a-f show a potified at ouce.	Funeral Directo	3 Nann Avenue 11. Marital Status 12. Was Decedent Ever in U.S.		21225			U.S.A.	
ath w items	ner	1 Never Married 2 X Married Armed Forces?	. 13. Was D	specify Cuban, I	anic Origin? (Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - White,	American Indian, Black, etc.
ter de		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 V	es 2 X No	specific:		Consider	1.1.
urs af tural	à	or Dates:	16a. Decedent's			f work done	Specify. 16b. Kind of Bus	white
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		of working life. [10017111000000	in loods in loading
036 ithin	립	12	Truck I	river			Custom	Carriers
5-0036 lled within 72 hours at Hygiene I other than "natural the Medical Examin		17. Father's Name (First, Middle, Last)		18	3.Mother's Nar	ne (First, Middle, I	1	
21215-0036 ould be filed within 7 i Mental Hygiene is marked other than ie event, the Medica	Be	John J. Eline				e Abbott		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Montal Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matile event, the Medical Examiner must be notified at once.	9	19a. Informant's Name/Relationship (Type, Print)					nber, City or Town,	State, Zip Code)
	ŀ	Mrs. Betty M. Eline / wife 20a Method of Disposition	3 Nanr	Avenue	; Broo	klyn, MD		
Ore		1 X Burial 2 Cremation 3 Removal from State cre	ematory or other	place)		Date	20c. Location - (City or Town, State
timent rtant:		4 Donation 5 Other Specify Loue	don Park	Cemete	ry 4	-18-2006	Baltime	ore, MD
20a. Method of Disposition Solid								Home, PA
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. I	2 I S	node of dving su	ve SW;	Glen Bu	rnie, MD	t Approximate Interval
/Medical failure List only one cause on each line.								Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a Multiple Injuries associat Due to (or as a consequence of):		ning				Death
		Sequentially list conditions, b						
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
.=	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
ecuted and trans	삚	dd						
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retain. retor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED						
6876 certificate nding phy	Ž	IF FEMALE: 23b. Was decedent pregnant in the			1		23d. Date of d	elivery
Sox 6876 leath certificat e attending phy for use as the	cial	past 12 months? 4 Pregnant at time of deat	2 Fetal	death 3 (Specify)	Ectopic pregi	nancy	Month	Day Year
Box e death c the atten ed for us	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	o Other	(Зреспу)				
o. hat the	by P	Part II. Other significant conditions contributing to death but not res	ulting in the unde	erlying cause giv	en in Part I.			ute to the cause of death?
S, P.C						1 Yes	2 No 3	Probably 4 🗸 Unknown
ords w requi	Completed					24a. Was autop		ere autopsy findings available or to completion of cause of
Reco	mo						med? dea	ath? Yes 2 No
tal Rection: The certificate ector, page	Bec	25. Was case referred to medical examiner?		26 Place of	f Death (Chec			103 2 100
of Vital Records, ng Physician: The law requir fier this certificate has been sineral director, page 2 should be	힑	1 Yes 2 No Hospital 1 Inpatient 2 E	R/Outpatient 3	DOA	ther ₄ Nurs	ing Home 5	Residence 6	Other: Scene
Ing P		1 Network (Month, Day, Year)	28b. Time of Injur	, , , , , ,			now injury occurred	
Sior Vittenc death ctor:	ätic	2 Accident Investigation Apr 12, 2006	1309 hrs		s 2 🗸 No		spitated from	bridge
Division ital or Attendiurs after death.	ertification:	3 Suicide 6 Could not be determined (Specify) Physics	ne, farm, street, fa	actory, office buil	ding, etc.	or Town, S	tate)	or Rural Route Number, City
bo by	O	4 Homicide (Speedy) Rivel				Patapsco Ri	ver at Intersta	te 695, Dundalk, MD
To the H within 24 To the F complete	Medical	check only one) 2 Wedical Examiner: On the basis of examination and	e, death occurred I/or investigation,	at the time, date in my opinion, d	and place, ar leath occurred	d due to the caus at the time, date	e(s) and manner a and place, and due	s started to the cause(s)
To the within To the Comple	Me	29b Signature and title of certifier		29c. License r				(Month, Day, Year)
	,	10/11/16		O.C.M.			April 13, 200	
	-	30. Name and address of person who completed cause of death (frem 2:	3a)	1				
8		Theodore King MD. Assistant Medical Examiner	,	Street, Baltin	more, MD	21201		
Sta	_	31. Date filed (Month, Day, Year) 32. Egistrar's Signature						
Regist	rar	APR 1 8 2006 Regues B	A CORN					

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		•	For State Registrar	State of Maryland	Department / Depar				giene 006	2 10
	Physici	an	1. Decedent's Name (First, Middle, Last)	ELSWICK	,			2. Date of Dea		3. Time of Death 527 AM
	/Medic Examin	er	4a. Facility Name (If not institution, give : Whi) VE(S) V OF MAY 5. Social Security Number 6. Sex	street and number) (Y) And Maica 7. Age (In yrs. last	Ctr B	altin or 1 Year	r Location of Death O C If Under 24 Hrs. Hours Min.	8. Date of Birtl	4c. County of De	Birthplace (State or Foreign Country)
ale	Director		Usual Residence of Decedent	M 2 F 76	Yrs.	Days	Hours Min.	July 2		КУ
	e Marylar a-1 ehow	ctor	no CARRO		own or Location	TER	2			10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28 Ist be no	al Director	10e. Street and Number 4114 OLD	WASHINGTON	1	ip Code	1157		10g. Citizen of What U	Country?
036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 ehow the Madical Examinar must be notillist at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1953		ecify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ai Black, W Specify:	merican Indian, hite, etc. White
21215-0036	d within 72 ho piene. Ir then "natur Ine Madical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	Colfege (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done use retire	during most of wor d)		16b. Kind of Busine Westing	
	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) ERVIN ELS	WICK			4		Maiden Sumame) WEBB	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat", or items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Examinar must be notified at once.	. 1	19a. Informant's Name/Relationship (Ty ALTAMACICELSW) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	CK / WIFC 20b. Plac com) WA	ASHINGTO	N ROAD	r, City or Town, State WESTMI 20c. Location - City SYKCSVI Ne	OSTPL MO 21157 or Town, State
Baltii	permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service Licens	nbrun	60 28	and Addre	ss of Facility W	DAD EL	DEAS BURG	no 21784
	Physician /Medical Examiner	Examiner	23a. Wartt. Enter the disease, or complished, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flag, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Strong Caused the death. In e cause on each line. Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	nce of):	as or ayır	ig, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
O. Box 68760,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical E	IE FEMALE:	d. 3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat	y eath 3⊟Ectopic		у		23d. Date of Month	delivery Day Year
ds, P.O.	ires that the de signed by the a 1 be detached to	þ	Part If. Other significant conditions co	ntributing to death but not resulting	ng in the underlying	cause giv	ven in Part I.	1		e to the cause of death? Probably 4 Munknown
Division of Vital Records,		Completed						24a. Was	an 24b. Were	aulopsy findings available to completion of cause of ? es 2 \(\) No
Vita	Physician: 1 r this certificer ral director, p	Be	25. Was case referred to medical examiner?	Hospital: 📈		Ott	200	ath (Check only o	<u> </u>	
on of	di is	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Minpatient 2 LEP	NOulpatient 3 [] Bb. Time of Injury M	28c. Inju	4 Nursing r		dence 6 Other (S	Specify)
Divisi	5	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, streel, facto	ory, office		28f. Location (5 City or Tow		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in h	Medical C		sician: To the best of my knowle iner: On the basis of examination and manner stated.						
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	. ~	2	~	se number		29d. Date signed (M	/
	141		30. Name and address of person who c	ompleted cause of death (Item 3)	3a) (Type Print)		1701			2006
	St. Regist		And Sancher MD 31. Date filed (Month, Day, Year) APR I 8 2000	ompleted cause of death (Item 2:	Well	ne s	hreet Ba	Thmore,	(m) 21	201

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Maryland / [Departme <i>Certifica</i>			d Mental Hy	giene Reg. No.	006	12105		
	Physic		1. Decedent's Name (First, Middle, Last)							ate of Death lonth Day Year 3. Time of Death				
	/Medi Exami		Crystal A. 4a. Facility Name (If not institution,			4b. <u>C</u> i	ty, Town, or	Location of De		4c.	County of Death	15.57		
			5. Social Security Number 6	0000	SPITAL 7. Age (In yrs. last bin	thday) If Uni	ALT der 1 Year	MOCE If Under 24 H	Hrs. 8. Date of Bit	rth	a Sinh	place (State or Foreign		
	Funeral Director		219-78-8284	1 ☐ M 2 🛣 F		Yrs. Month			1in. (Month, Di 09/30/1	ay, Year)	Cou	yland		
	and **		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d, Inside City Limits		
	Marylan of ehow	tor	Maryland			timore						1 XYes 2 No		
	or 28a-f	Director	10e. Street and Number			10f.	Zip Code			10g. Cití	zen of What Cou	intry?		
	death with the Maryland ms 23a or 28s-f ehow crosse be notified at													
	15-0036 72 hours after death w "neturel", or Items 23e	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For	2X No	If Yes, s	pecify Cuba	n, Mexican, Pu	erto Rican, etc.)	0-	14. Race - Ameri Black, White	etc.		
	OO36	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	tes:	1 □ Yes	2 🛣 No	Specify:			Specify: B1	ack		
	15-(in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		Decedent's U (Give kind of life. DO NO	work done c	turing most of	working	16b. Kii	nd of Business/Ir	ndustry		
	212 d withi giene.	omo	Elementary/Secondary (0-12)	Coltege (1-	4or 5+)	Comput		,		Co	mputer			
	Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event; the Marical Examinar must be notified at once.	Be	17. Father's Name (First, Middle, La						Name (First, Middle ne Johnso		Sumame)			
	should and Mer market	2	James Robert Mc 19a. Informant's Name/Relationship			Mailing Addre	ess (Street a		Rural Route Numb		r Town State Zi	p Code)		
	Marth ar 27 is Br trau		Derrick Mc Lean	90	1				Baltimo					
	Baltimore, bermit. Peges 1 at Depertment of Hea mportent: If Item iny injury or othe 2006.		20a. Method of Disposition 1 XBurial 2 Cremation 3		20b. Place of cemeter	Disposition (f y, crematory o	r other plac	1 1/4	Date / 20/2006		cation - City or T			
	Itim it. Peg ortment ortent: njury		4 Donation 5 Other (Spe 21. Surature of Funeral Services Li	cify)	King M	emoria.		Ceme.	he Derric			Maryland		
	Dennii Depe		21. Statute of Foliatal Salvicas	()								Land 21215		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	emplications that cally one cause on ea	ged the death. Do ruchtine.	not enter the m	ode of dyin	g, such as card	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. CAR	DIAC AR	RHYTI	ym/	9				Thour		
-	Examiner				or as a consequence	,						rday		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									7		
	60, be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c. ENDue to (c	or as a consequence of	<i></i>	W.	C711	J	_	-			
	8760, cate be ex physicien the buria	dical		d										
	certifica certifica ding ph	Med	IF FEMALE:	00-14							1			
7	Bath atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live bi	ome of pregnancy rth 2 Fetal death ant at time of death	3 ☐Ectopic				2	23d. Date of deliv Month	Pery Day Year		
57.8	P.O. that the dead by the detached	hysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkno			(-,							
ORYSTAL	ords, P. requires that een signed b	þ	Part II. Other significant condition			tobacco use contribute to the cause of death? Yes 2840 3 Probably 4 Unknown								
C		eted	THROMBOTIC THROMBOLY TO PENIA PURPURA											
5	Vital Rec stolen: The law certificate hes b lirector, page 2 sl	Completed			auto perfe	24a. Was an autopsy performed? 1 Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No								
PEEMAN	on of Vital Reding Physicien: The Programme After this certificate he funeral director, page	BeC	25. Was case referred to medical examiner?						Death (Check only	one)				
113	of Vita Physicien: rithis certific	2	1 Yes 2 No		patient 2 ENOu	tpatient 3	DOA Othe	er: 4 ☐ Nursin	g Home 5 Res			fy)		
RE		ation	27. Manner Leath 28a. Date of Injury 1 Latural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 38d. Describe how injury occurred Work? 1 Pending 1 Per 2 No											
F	Division tor Attending after death. Director: After	Certification:	3 Suicide 6 Could no determin	A 288. Place	of Injury - At home, fa g, etc. (Specify)	rm, street, fact	ory, office		28f. Location (City or To			al Route Number,		
	pital o		29a. Certifier La Certifying	Physician: To the	best of my knowledge	death occur	ad at the tim	no, date and pl	ace, and due to the	031150(5)	and manner as	Tated.		
(1)	Divisi To the Hospital or Atten within 24 hours atter deat To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Ex	aminer: On the ba and mann	sis of examination and	d/or investigati	on, in my or	pinion, death o	ccurred at the time,	date and	place, and due t	to the cause(s)		
	To the To the Comp	×	29b. Signature and title of certifier	1			29c. License			29d. Date	signed (Month,	Day, Year)		
	\cap		30. Name and address of person wi	Lang On	of death (from 22c)	Type Print)	1)2	26YF		APR	1413,2	006		
			JEROME I	-	mp. 9	00 Sen	TH CA	TON AU	enue Ba	Hin	zere Mi	anland		
	St. Regist	ate rar	31. Date filed (Month, Day, Year)		gistrar's Signature	house	1				7	anyland Piezs		
I	1 logist		APR 1	R 2008	Excited do	See See Co	_							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** HARLEST FOL 2006 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RTHN RANDALLITOUN
If Under 1 Year If Under 24 Hrs. Baltimore MOSPITA Min March 16, 1936 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**M 2□ F 70 Yrs. France Director 577-50-0863 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a. State other than "naturel", or items 23s or 28s-f show vent, the Medical Exeminar must be notified at 1 Yes 2 □ No Baltimore Directo Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21215 4800 Seaton Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: Caucasian Baltimore, Maryland 21215-0036 11/29/61 1 ☐ Yes 2 X No Specify: <u>۾</u> 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) Coltege (1-4or 5+) Elementary/Secondary (0-12) Private Industry Insurance Broker 12 4+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tent: If Item 27 is marked off jury or other traumatic even Frances Ireland Charles S. Foltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Sister) 633 East Drive, Memphis, TN Nancy Foltz Vest 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny injury or once. 04/15/06 Catonsville, MD. 21228 Metro Crematory Inc. 22. Name and Address of FacilitLoring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** ESPIRATORY /Medical Due to (or as a consequence of): Examiner PNEUMONIA

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury that initiated events resulting in death) Last Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the ettending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cete hes been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No To the Funaret Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 17 Natural Attending 5 Pending 1 ☐ Yes 2 ☐ No М investigation after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number D006 3 of person who completed cause of death (Item 23a) (Type, Print) BELVEDERE NG11 2401 MANDEE 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#16a,perFh (354.4/18/06 TT Department of Health and Mental Hygiene Commonwealth For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0:41 AM 2006 APITI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Center da BALTIMORE VorThwest HOSPITa If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07/18/1935 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 220-30-4009 70 MD Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Pages 1 and 2 should be tiled within 72 hours after death with the Marylan neat of Health and Mental Hygiene.
ant: if tem 27 is marked other then "natural; or items 23a or 28a-f show ury or other traumatic event, the Madical Examinar must be rediffied at MD N/A BALTIMORE 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 7241 PARK HEIGHTS AVENUE APT. D 21208 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **TELEMARKER** Telemarketer MORTGAGESALES 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **FELDSHER** PHILIP UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA FELDSHER-HELMAN/DAUGHTER 12 BUCKSWAY ROAD - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of himportant: If Ite any Injury or of once. 04/17/2006 HEBREW FRIENDSHIP BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) re f Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of the spiral of the Interval Between Onset and Death Immediate Cause (Final **Physician** Multiple organ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Systemic inflammator response Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner led by the attending physicien and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed ditticile Clostridium CO resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 11 Yes 2 □ No palmonary 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sleep apried autopsy performed? Yes 2 No pathyroidism 2 🗌 No 1 Yes 1 Yes aroxysma 25 Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 Y No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Manner of Death 1 [Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After s etter dea. •al Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 Homicide To the Hospitel within 24 hours e To the Funerel Completely tilled in 1 To cartifying Physician: To the best of my knowledge, death occurred at the time, date and diace and diace to the cause(s) and menner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462 April Socton MD 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland Northwest Hospita Boston 31. Date filed (Month, Day, Year) 2. Registrar's Signature APR 1 8 2006 Registrar

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Maryland -f ehow	ind at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD N/A BALTIMORE									10	0d. Inside City Limits 1 X Yes 2 □ No		
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Baltimo	eny in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208										MD 21208	
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l	U		30. Name and address of person who con PRANITHA NAIN		eath (Iten	n 23a) (Туре, Г ҮА І Р	Print)							Inden AV
Re	Stat gistra		31. Date filed (Month, Day, Year)	32 degistr	ar o organo	ature	all .	rei P					13altin	NO 2121

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	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month, Day, Year)
	15		30. Name and ad 14 ss of person who co	moleted cause of death (Item 23a)	Type Print	A	-117/00
	1		Mini Panil	ar 750 1	Kunst, Pels	steresto	en, MD 21136
	Sta Registra		31. Date filed (Month, Day, Year)	22. Registrar's Signature	hearth)		,

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		For State Registrar	State of Maryland		artment of H rtificate of L		Re	g. No.	2110
Physic		1. Decedent's Name (First, Middle, Last) Catherine	e R. Glenn				2. Date of Death Month April	2 Day 2006	3. Time of Death
/Medi Examii Funeral		4a. Facility Name (If not institution, give si Manor Care Hea] 5. Social Security Number 6. Sex	th Center 7. Age (In yrs. lass	t birthday)	4b. City, Town, or Silve. If Under 1 Year Months Days	r Sprin	ng	4c. County of Death	1
Director		Usual Residence of Decedent	M ¾ □ F 85	Yrs.		Hours Will	Sept. 1	4,1920	S.C.
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Diractor: After this certificata h completely filled in by the funeral director, page	ation: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		VOutpatier Bb. Time o Injury	f 28c. Injur Wor	er: 4 🖼 Nursing	Home 5 Resider 28d. Describe hor	nce 6 Other (Spec	cify)
pital or Atte	I Certification:	3 ☐ Suicide 6 ☐ Could not be determined 29a. Certifier 1 ☑ Certifying Phys	28e. Place of Injury - At hom- building, etc. (Specify)			ne date and alon	City or Town,		
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		ar: On the basis of examination and manner stated.			pinion, death occ	surred at the time, da		to the cause(s)
2		30. Name and address of person who co	STOWN RO	AD	Print) RA. SUITE	MAN 202 (P. T LAITHE	CILI. "	MD268
St Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e	and				

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			Usual Residence of Decedent					Aug	. 10,	1721 191000	grana
	yland		10a. State 10b. County	10c. City, Town		,					10d. Inside City Limits
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	ith th	Olre	10e. Street and Number	,	10f. Zip		01001		10g.	Citizen of What Co	untry?
	ath w	ra	8835 Green Needle D				21236			U.S.A.	
	ter de	Funeral Director	Ar	as Decedent Ever in U.S. ped Forces? Yes 2 \(\sum \) No	If Yes, spec	ify Cuba	n, Mexican,	jin? (Specify Yes , Puerto Rican, e	etc.)	14. Race - Ame Black, White	
336	al', or	by F		res, Give ar or Dates:	1 ☐ Yes	2 ⋈ №	Specify:			Specify:	White
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Exart are must be rodified at	ted	15. Decedent's Education (Specify only highest grade com	16a. (Decedent's Usua Give kind of wo	d Occupa	ation	of working	16t	o. Kind of Business/	Industry
21	within 7 ene. than "r	Completed		llege (1-4or 5+)	life. DO NOT us	e retired)	or working			
	ygian ygian yer th	Cor	8		ruck Dr	wer		4- N (Fi)		eamsters	uncon
Maryland	Ibe fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last) John Greenwald					r's Name (First, all Z	мідаю, маіі 2010	uen sumame)	
7	d Me	스	19a. Informant's Name/Relationship (Type, Pr	int) 19b.	Mailing Address	(Street a			• •	ity or Town, State, 2	Zip Code)
Ma	d 2 s Ith an 27 is		Patricia Greenwald		•					igham, MD	21236
	Heal Heal Hem		20a. Method of Disposition	20b. Place of	Disposition (Nari	ne of	1	Date	-	. Location - City or	
E O	Page: ent o nt: if ry or		1 🗓 Burial 2 □ Cremation 3 □ Remov `4 □ Donation 5 □ Other (Specify)	attrom State			· .	4/21/06	Bo	ultimore.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marjan Exam are must be putified at once.		21. Signature of Funeral Service Licensee	1						ineral Hor	
m	8 3 5 8		Melle		9705	Bela	ir Rd	., Balt	imore,	MD 2123	5
8760, F.	Wedical Examiner one prival-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or according to Due to (or accordin	struct n:		-	ì	-		Approximate Interval Between Onset and Death
P.O. Box 68	death certifica e attending ph d for use as tl	Physiclan/Med	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □ Unknown	3 ☐Ectopic pr 5 ☐ Other (sp				302	23d. Date of del Month	ivery Day Year
	es tha gned be de	by	Part II. Other significant conditions contribut	ng to death but not resulting in	the underlying c	ause give	en in Part I.	230	a. Did tobac 1 ☐ Yes		the cause of death?
Records,	e law has b	Completed			-				a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	ac			26. Place	of Death (Check			70 40
Į (ys di:	To	1 ☐ Yes 2 XNo Hospit	al: 1 ☐ Inpatient 2 ☐ ER/Out		_	4 140	rsing Home 5[Residenc	e 6 Other (Spe	or rieni's
0	ding Ph h. After th funeral		27. Manner of Death 28 1 Natural 5 ☐ Pending	a. Date of Injury 28b. Ti (Month, Day Year) In		8c. Injury Worl			scribe how i	injury occurred	7,10.31.30.7.31.7.31.2
Sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	Diago of Injury At home for	M dental factor		Yes 2□h		ation (Stree	at and Number or Ri	ıral Route Number
Division of	or At after Direction by	Certification;	4 Homicide determined 28	 Place of Injury - At home, far building, etc. (Specify) 	m, street, ractory	/, опісе			or Town, S		na noute rumber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			: To the best of my knowledge,							
	the Ho nin 24 h the Fun npletaly	edical		In the basis of examination and manner stated.				th occurred at the			
	To the To the comp	ž	29b. Signature and title of certifier	Physician	290	License	975	2)	29d.	Date signed (Mont	
	7. 1		P annalls	· · · · · · · · · · · · · · · · · · ·			,			4-18-	
_	541		30. Name and address of person who completed the series of	9114 Hilac	elphio	80	Su	itc 300	BA	HOTO MD	2/237
	Sta Regist		31. Date filed (Month, Ray, Year) 8 200	32. Ragistrar's Signature	A 100 A 100	A. C. C. C. C. C. C. C. C. C. C. C. C. C.					

			1 - For State Registrar	State of Marylan		artment rtificate			nd Mental H	ygien	. U U O		2112
7	Physici	à ₂	1. Decedent's Name (First, Middle, Last)						2. Date of I	Death	ıv Ye	aar	Time of Death a
	Physici /Medic				nnon				Apri1	16 2	2006	-	11:00 M
ALC: WA	Examin	er	4a. Facility Name (If not institution, give str	reet and number)		_	own, or aden	Location of D	Death		County of E		County
<i>F</i>	Funeral		168 Dale Road 5. Social Security Number 6. Sex,	7. Age (In yrs.	last birthday)	If Under 1	Year	If Under 24	Hrs. 8. Date of I				
20	Director		215-24-0064	^{M 2□ F} 76	Yrs.	Months	Days	Hours	Min. B. Date of I Dec.	15,19	29	Maryla	(State or Foreign and
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d In	nside City Limits
	Maryli -f sho	tor	Maryland Anne Aru		asaden							1	☐Yes 2 No
	h with the	ai Direc	10e. Street and Number 168 Dale Road			10f. Zip (.122		10g. Ci	tizen of Wha		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if itam 27 is marked other than "neturel", or itema 23a or 28a-f show important: if itam 27 is marked other than "neturel", or itema 23a or 28a-f show striply or other traumatic event, Ire M. of cal Extratract must be multified at once.	Completed by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decede f Yes, specif		spanic Origin n, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-		American In White, etc. White	dian,
9	2 hou	ted	15. Decedent's Educa	ition	16a. Dece	dent's Usual	Occupa	tion	f	16b. H	(ind of Busin	ess/Industry	/
215	ithin 7 18.	npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use	retired)		r working				
7	lled w tygier ther th	Cor	12 17. Father's Name (First, Middle, Last)	0	Se	1f-Em	-		Name (First, Midd		nousin	e Comp	pany
Maryland 21215-0036	d be f	To Be		Sr.						eavei	ŕ		
ary	should be and Mental marked c	F	19a. Informant's Name/Relationship (Type		19b. Mailin	ng Address ((Street a		or Rural Route Nun			te, Zip Code	9)
Σ	and 2 Balth a n 27 is		Michael B. Gannon	(Son)					Baltimor	e, Ma	arylan	d 2123	37
ore	Pages 1 nent of He int: if itar iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Rep		Place of Dispo semetery, cren				Date		ocation - City		
Baltimore,	rtmen rtant: njury		4 Donation 5 Other (Specify)	1	ownsvil				4-20-06				aryland
Ba	permit. Departr import		21. Signature of Funeral Service Licensee	Danne	Mg	Cully 3204 M	-Pol	yniak ain Ro	Funeral pad, Pasa	Home dena	P.A. Mary		
	Physician		23a. Pari 1. Enter the disease, or complication hock, or heart failure. List only one lamediate Cause (Final disease or condition resulting in death)	ations that caused the deatl	h. Do not ente	er the mode	of dying	, such as car HAB	ETES	arrest,		Inter	roximate rval Between et and Death
¥.	/Medical Examiner		Toolsting in doubly	Due to (or as a conseq	uence of):	0 - 0	0 -	0					
		Jer.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):	<u>ono</u>	25	4					
d	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.										
3760,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or as a consequ	uence of):								
	physics the t	dical	d.										
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of do 9 ☐ Unknown	ideath 3	Ectopic pre Other (spe				-	23d. Date of Month	delivery Day	Year
	s that med b e deta	by Ph	Part II. Other significant conditions contr	ibuting to death but not resi	ulting in the ur	nderlying car	use give	n in Part I.	23e. Did	d tobacco	use contribut	te to the cau	use of death?
ğ	w require been sig should b	ted t	Hyperlens	scon	7)				10	Yes 2	No 3[] Probably	4 Unknown
l Records,	The law nete has be page 2 sh	Completed	Hyperchi	Cescerot	em	ia			24a. Wa au pe 1 🗆 Yes	topsy rformed?	prior	to complete h?	ndings available ion of cause of No
/ita	cian: sertific ector,	Be	25. Was case referred to medical examiner?	anital:			Lou		Death (Check onl)	(one)			
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on	th: Afte	ation	Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	м	c. Injury Work	? es 2∐No		0 1.044 1.110	ry occurred		
Division of Vital	if or Attend after death Director: ,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory,	office		28f. Location City or 7	(Street ar	nd Number o	r Rural Roul	te Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kno or: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a	t the time	e, date and p inion, death o	place, and due to the	e, date an) and manne d place, and	r as stated. due to the c	cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	12 7		-	License			29d. Da	te signed (M	onth, Day, \	Year)
)	4		John W.	Downe W	119	l.) 2	064	49	4	171	06	
	XXI		30. Name and address of person who com		23a) (Type,	Print)		一 书	190z. B/	1 7 1	4000	417	21201
0	Sta	to	JOHN W. BOW I 31. Date filed (Month, Day, Year)	E. M.D. 610) (JI 4	1402, DI	+6111	TUKE,	140	21204
	Registr		APR 1 8 2006	Status B.	dure	Es.					_		

			1- For State of Marylan	-	artment of Health an	100	ene 006 12113
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year
	/Medic	al	Thelma Marie Gott		4h Cir. Taur as Lacation of 5	April 7	2006 2.04 PM
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of E		,
	Funeral		St. Joseph's Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	Towson If Under 1 Year If Under 24	Hrs. 8. Date of Birth	Baltimore 9. Birthplace (State or Foreign Country)
	Director		214-26-9533 1 1 M 2XF 91	Yrs.	Months Days Hours	Min. (Month, Day,) Oct. 27	
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	ocation		10d. Inside City Limits
	darylan f show	٥	MD Baltimore		eysville		1 ☐ Yes 2 No
	r 28e	Director	10e. Street and Number	COCKE	10f. Zip Code	100	g. Citizen of What Country?
	th with	al D	300 International Circle		21030		USA
	ems erm	Funeral	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- querto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No II Yes, Give 9 3 ☑ Widowed 4 ☐ Divorced 1 ☐ Year or Dates:		1 ☐ Yes 2 XNo Specify:		Specify: white
21215-0036	72 hours after death with the Maryland neturel; or Items 23e or 28e-f show Jisel Evar, it art must be nodified at	ed	15. Decedent's Education	16a. Dece	dent's Usual Occupation	10	6b. Kind of Business/Industry
215	within 72 ene. then "no	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of DO NOT use retired)	f working	
21	ed wit	Completed	12 4	Reg	istered Nurse		Nursing
and	12 should be filed within h and Mental Hygiene. 7 is marked other then "Ireumatic event, then Mer	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, Ma	,
Maryland	hould d Mer marke matic	2	Thomas O. Isennock 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number of	nce Montgor	
Ma	and 2 s salth an n 27 is i		Lynda Van Der Snick/daughter		46 Deveron Rd.		ID 21234
re,	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyghen. If item 27 is marked other then "neturel, or items 23e or 28e-f shoy or other treumatic event, I'm Medicul Ever' if ar must be notified at		20a. Method of Disposition 20b.	Place of Dispo	osition (Name of matory or other place)		Oc. Location - City or Town, State
m	Page nent c ant: If ury or		1 🗆 Burial 2 💢 Cremation 3 🗀 Hemoval from State			12/06 C	atonsville, MD
Baltimore,	permit. Pages 1 and 2. Department of Health at Importent: If item 27 is any injury or other treu		21. Signature of Funeral Service Licensee Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the de-	// 22	2. Name and Address of Facility		
			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	. Cerr	dio Vasculen	Evert	575514.10 5541.1
1	/Medical Examiner		Due to (or as a conse	quence of):			
	_	er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):			
	outed id ansit	Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events				
0,	be executed ician and burial-transit	Exa	resulting in death) Last Due to (or as a conse	quence of):			
8760,	icate be executed physician and sthe burial-transit	dical	d				
9 ×	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregr	nancy			23d. Date of delivery
Box	atten atten	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)		Month Day Year
0	t the d by the achec	hysi	9 Unknown 9 Unknown				
s, P	ss that gned I			sulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
Records,	n require been sig should b	Completed by	Congestie peut taline	Hou	u. Huses	1 ☐ Yes	2 No 3 Probably 4 Winknown
ec	has by ge 2 st	npie	Hypo pyroulisi, Very	heat	Versculen	24a. Was an autopsy performs	24b. Were autopsy findings available prior to completion of cause of death?
	r. The			ier		1 Yes 2	XNo 1 ☐ Yes 2 XNo
Z.	Physicien: this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 D	XER/Outpatier	Othor	Death (Check only one)	ce 6 □Other (Specify)
of	y Phy er this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time o		28d. Describe how	
ion	Attending r death. sctor: Afte	atio	2 Accident investigation	Injury	M 1 Yes 2 No		
Division of Vital	or Atterde directorin by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec		reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	urs af	Se					
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my kr (Check only one) 2 Medical Examinar: On the basis of examinar and manner stated.				
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month, Day, Year)
	> - 0		R.t. Filetoms.		D21464	1	4/11/06
	-		30. Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print)	0.4	-
	2		ROBERT LIBERTO, MD. 350	8 BO	inh ST Ba	eti, mil	21224
	Sta Regista		31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature	beede	,	
	5.01		AFK X ZUUD MAGGEL	Por pos			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1 18 19 per MD. FH. 0854 4/18/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Iosif Gerchikov **Physician** Month Year 38 A M APR 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLST V BALTIMORE NORTHMER CENTER HOSB 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 218-27-0006 09/23/1921 RUSSIA Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle rthan "natural", or Iteme 23a or 28a-f ehov tre Medical Exacting must be notified at MD HOWARD COLUMBIA 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 CRADLEROCK WAY #620 21045 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. WHITE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CIVIL ENGINEER CONSTRUCTION permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other 11 any Injury or other traumatic event, III.a. 2006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raikhline **GERCHIKOV** BORIS KAISA -RAIKLINE ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mi 11 718 COCKEYS MILLS ROAD - REISTERSTOWN, MD 21136 RAISA GERCHIKOVA / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CONG 04/16/2006 REISTERSTOWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CARDITVASLULAR **Physician** SCIERD PIC /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burflat-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 2 R/Outpatient Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tes 2 No investigation 2 Accident 3 🗍 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00024970 ABRIL 12 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DID COURT RPAD RAWDALLSTOWN. 5401 CLIFF BER FA

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 8 2006

32. Degistrar's Signature

			1 - For State Registrar		larylan		artment of H tificate of L			Reg. No.	6 12	
ı	Physici	ian	Decedent's Name (First, Middle, Las HILDA	t)		G	AMBEL		2. Date of De	14 [°] , 2006	3. Time of 2:15	of Death A M
j	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De	eath	4c. County of		
	Funeral Director		5. Social Security Number 6. Se 214–22–0068	9X 7. A	ge (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	10/13/2	r928	Birthplace (State Country) M	
	Maryland f show	tor	10a. State 10b. County MD BALTIMO)RE	10c. Cit	y, Town or Lo BALTI					10d. Inside C	City Limits
	deeth with the Marylan ns 23a or 28a-f show mat ke notiffed	al Director	10e. Street and Number 1840 REISTERSTON	NN ROAD	.1,		10f. Zip Code 21208			10g. Citizen of Wha		
5-0036	within 72 hours affer deeth with the Maryland ene. then *natural', or Items 23e or 28e-f show ta Modical Exemiter must ke modified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 T If Yes, Give Year or Dates:	? No		Was Decedent of Hi Yes, specify Cuba	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No uerto Rican, etc.)	14. Race- Black, Specify:	American Indian, White, etc. WHITE	
0-61212	s within 72 ho piene. r then "natur the Medical.	Completed	15. Decedent's Ed (Specify onfy highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or	5+)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	turing most of	working	16b. Kind of Busin		
/land	should be filed nd Menfal Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) DAVID			Р	ARIS	18. Mother's I ESTH	Name <i>(First, Middl</i> e, ER		REEDMAN	,
Mary	s 1 and 2 shou f Heelth and M Item 27 is mar other traumat		19a. Informant's Name/Relationship (7	^{Гурө, Print)} GHTER			-		- LUTHER			
ilmore,	8 = 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State		lace of Dispo emetery, cren L YAAK	sition (Name of natory or other place OV	04	Date /16/2006	20c. Location - Cit	ty or Town, State	
Pail	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Licen		,		SRAEL CON 8900 REIS		SOL LEVII WN ROAD -		-	
	Physician		23a. Part / Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each i	d the death ine. CDSC	Do not ent	1		diac or respiratory are	1	Approxima Interval Be Onset and	tween
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as								
8/60,	sate be executed physicien and the burial-fransit	Ical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	·	,						
O. Box 68	ath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of Month		Year
cords, P.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	intributing to death t	out not resu	ulting in the ur	iderlying cause give	on in Part I.		bacco use contribu		death?
Ψ	2 5	Completed							24a. Was autop perfor	med? dea	re autopsy findings r to completion of c th? Yes 2 No	available cause of
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		cD/O	Othe	r /	Death (Check only o	ne)		
lon or	nding Physician: The tath. ath. r: After this certificate ha ie funeral director, page	atlon: To	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Inju		£R/Outpatien 28b. Time of Injury	28c. Injury Work		g Home 5 Resid	ow injury occurred	Specify)	
DIVISION	ital or Atte irs affer de raf Directo led in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, e	tc. (Specify	/) 	eet, lactory, office		City or Tow			nber,
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: Atter it completely filled in by the tunera	Medical	one) 2 Medical Exam	ysician: To the best iner: On the basis of and manner st	of examinat	wledge, death tion and/or inv	estigation, in my op	oinion, death o	ace, and due to the occurred at the time, o	date and place, and	due to the cause(s)
•	Twiting 1		29b. Signature and title of certifier	fallic	2mi		29c. License	195-	n.	29d. Date signed (A	5	
	lê .		30. Name and address of person who de TASNEEM	ompleted cause of a	death (Item	7220 7220	Print) PARK	HEIC	Sotts A	E BA	ero MD	21201
	Sta Registr		31. Date liled (Month, Day, Year)* APR 1 8 20	32. Peg istr	rar's Signa	ture /	www.					

			For State Registrar	State of Mar	ryland / Depa <i>Cel</i>	artment of H			ene	6	1216
T	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death	Day	Year	3. Time of Death
No.	/Medic		Edward B. Ha					April	14 20	006	8:25 PM
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County		
	**************************************		132 Virginia A 5. Social Security Number 6. Se		(In the last himbol)	Es:	SEX If Under 24 Hrs.		Balti		
1	Funeral Director		212-03-3627		(In yrs. last birthday) 99 Yrs.	Months Days	Hours Min.	8. Date of Birth Jan 19	, 1907	Mar Mar	place (State or Foreign Tyland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary feb	jo	MD Baltim	ore	Esse	х					1 🗆 Yes 2 🛣 No
	28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?
	h with		132 Virginia	Ave.		21	221		USA		•
Maryland 21215-0036	a within 72 hours after death with the Maryland jiene. rithan "natural", or items 23a or 28a-f ehow it a Madical Exa ultuer must be mullified at it a Madical Exa ultuer must be mullified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ Myo	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	Blac	e - Americ k, White, Whi	
0-0	72 ho	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Bu	siness/In	dustry
21	within 72 ene. than nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retired	during most of work 1)		Trans	ort	ation
2	e filed within al Hygiene. other than vent, it e his	Co	10th		Ye	llow Cal		r _			
and	D 72 D 0	Be	17. Father's Name (First, Middle, Last) Harry H. Harv	AV				e (First, Middle, M Bloxor		Θ)	
3	should bent marked umatic e	L C			1 10 11						
Mai	12 sho		19a. Informant's Name/Relationship (T) Edward HArvey	· · · · · · · · · · · · · · · · · · ·		ng Address <i>(Street a</i> 32 Virg:					Code) 21221
	s 1 and 2 should f Health and Men item 27 ie marke other traumatic		20a. Method of Disposition	01. / 50	20b. Place of Dispo	sition (Name of			Oc. Location -	1111	
nor	ages ant of it: If it y or c		1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Louden	natory or other plac Park	4/18		Baltin	-	
Baltimore,	permit. Pages Department of I Important: If Ite any injury or o		21. Signature of Funeral Service Licens	88	11 22	Name and Addres	ss of Facility 300	0 Mace	Ave. F	Balt	imore MD
	§ 1		23a. Part1. Enter the disease, or comer shock, or heart failure. Liet only or	cations that caused the						sex	Approximate
100	Physician /Medical		shock, or heart failure. Let only of Immediate Cause (Final disease or condition resulting in death)	Cop	SMAT	AMER		SEME			Interval Between Onset and Death
465.	Examiner			·	307.00 407.00						
		ner	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of).						
	cate be executed bhysicien and the burial-transit	Examiner	that initiated events	s							
o,	e exe ien al ırial-t		resulting in death) Last	Due to (or as a	consequence of):						
8760,	ate be hysici he bu	dlcal		d							
9	ing pl	Med	IF FEMALE:						1		
P.O. Box	that the death certificaned by the attending phates detached for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor		ny Day Year
	sign Sign d be	þ	Part II. Other significant conditions con	CSCDIDA		nderlying cause give	en in Part I.	23e. Did toba			ably 4 Unknown
Division of Vital Records,	The law ate has b page 2 s	Completed						24a. Was an autopsy perform	/ D	Vere autorior to coreath?	psy findings available inpletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one			
<u></u>	Q 50 Y	2	1 ☐ Yes No	lospital: 1 Inpatient	2 ER/Outpatien		4 - Industria Ho	me Residen	ice 6 □Othe	r (Specify	<i>'</i>)
ū	Jing P	on:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time of Injury	Work		28d. Describe how	v injury occurre	be	
sio	Attending r death.	cat	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 □ No				
DİVİ	Prospital or Attenc 24 hours after death Funeral Director: stely filled in by the	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Numbe State)	er or Rura	l Route Number,
	To the Hospital or Attending Phwithin 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	edical	one) 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	estigation, in my op	oinion, death occurr	and due to the cau red at the time, dat	use(s) and mai e and place, a	nner as st nd due to	ated. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	A.	1.0	29c. License	8025	296	d. Date signed		4
•	0		Potary Myth	fr you	M	V-9	0077		4-1	1-2	006
9	Υ		Softman Address of person who co	PNI, M		Print) (WESACO	Ave,	BALTS,	MD 2	-123	7
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Carl o					

ORIGINAL

		1	1 - For State Registrar	State of Marylar			nt of H		Mental H	ygien Reg. N	all lib	2 17
			Decedent's Name (First, Middle, Last)						2. Date of I	Death		3. Time of Death
	Physici		Bobby L. H	ewitt Jr.					Month	1 0	ay Year	11-49 PM
	/Medic Examir		4a. Facility Name (If not institution, give	street and number) , `	11	4b. City	Town, or	Location of Dea	th	4	c. County of Death	1
	LXamii	E1	Franklin Samo	. A Marla	tal 1	So	2050	edalo	·		Palti	More.
-	Funeral		5. Social Security Number 6. Sec	7. Age (in yrs.	last birthday)		r 1 Year	If Under 24 Hrs	8. Date of I	Birth	9. Birth	place (State or Foreign
	Director		217-88-0600 1X	3 M 2 □ F 3 M	1 Yrs.	Months	Days	Hours Min	Marc		9. Birth 1975 Ma	ryland
	υ		Usual Residence of Decedent									
	ylan how		10a. State 10b. County		ity, Town or Lo							10d. Inside City Limits
	Ma-f	Ş	MD Baltimo	ore M.	iddle	RIV	er					1 ☐ Yes 2 No
	h the	ire	10e. Street and Number			10f. Z	p Code			10g. C	Citizen of What Cou	intry?
	within 72 hours after death with the Maryland ane. then "natural", or items 23a or 28a-f ehow the Medical Examiner must be invitted at	Funeral Director	531 Kingston Ro	ad			212	20		US	A	
	dea	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		Was Dece	edent of His	spanic Origin? (S	Specify Yes or i	No-	14. Race - Amer	
g	or ite	F	1 Never Married 25 Married	1 Yes 2 XNo			2 % No	Specify:	to Hoarr, stc.)		Black, White Specify: Wh	
93	ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		103	2 A) NO	Specity.			Specify: VVII.	ite
21215-0036	72 h netu	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	kind of w	ork done di	urina most of wo	nrking	16b.	Kind of Business/I	ndustry
21	ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired)			T	owing	
7	Hygier Hygier ther ti	S	10th		Truc	K D				1		
P	be fial H d off	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na			,	
yla	should ind Men marke	မ	Bobby L. Hewi								n Valen	
Maryland	2 sh and i• m		19a. Informant's Name/Relationship (Ty								or Town, State, Zi	
	end lealth m 27		Mary Lynn Hewit					n Road		-		1220
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, if a Mudical Examiner must be notified at DDGs.		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R	amoval from State	Place of Dispos	natory or	other place		18706		Location - City or T ltimore	
Ē	Pa men tant: lury		4 ☐ Donation 5 ☐ Other (Specify)	56				f Jesu:				
3a1	permit Depertr Importa any inju		21. Signature of Funeral Service License		22	. Name a	nd Address	s of Facility 3	00 Mac	e Av	ve. Balt	to. MD
ш	202 = 3		R. Lirry	Comelli							f Essex	21221
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	Do not ente	er the mo	de of dying	, such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Finat disease or condition	0 1 0	cer	Me	te t	o hiv	rev/1	_un	ia	Onset and Death
	/Medical		resulting in death)	Due to (or as a consec		1115	11	11		F	7	
	Examiner		Sequentially list conditions	Kesbira.	tory	to	ilw	ve (F	rupo,	X19		
	р <i>≅</i>	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (dr as a consec	quence of	,			Λĺ			
	cute	Examiner	mai iimated events	Malignan	it Pl	eur	21	thu	SIONS	5		
0	death certificate be executed e ettending physicien and ind for use es the burial-transit	EX	resulting in death) Last	Due to (ur as a consec	quence of):			OV				
8760	ate be nysic he bu	dlcal		1								
9	ng pl	Med	IF FEMALE:									
Box	eath certific ettending p I for use es	Jue 1	23b. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		Ectopic	pregnancy			1	23d. Date of deliv	
	o dea	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of of 9 Unknown		Other (s				.	Month	Day Year
P.O.	that the de ned by the e detached f	Physician/Me	9 Unknown	3CI OTIMIOWIT								
	8 P. G	ρ	Part II. Other significant conditions cor	ntributing to death but not res	sulting in the un	nderlying	cause give	n in Part I.				the cause of death?
ğ	w requir been si should	Completed							1[Yes :	2 □ No 3 □ Pro	bably 4 Unknown
ပ္ထ	> 11 0	pie							24a. W	as an topsy	24b. Were aut	opsy findings available ompletion of cause of
ŭ	The ste he	E							pe 1 ☐ Yes	formed?	death?	
of Vital Records,	i i i i i i i i i i i i i i i i i i i	0	25. Was case referred to medical examiner?					26. Place of De				
†	ysic lis ce direc	To B	1 Yes 25 No	lospital: 1 Unpatient 2	ER/Outpatient	t_ 3[] D	OA Othe	r. 4 🗆 Nursing I	Home 5 ☐ Re	sidence	6 ☐Other (Speci	ify)
	ter th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	at	28d. Describ	e how inj	ury occurred	
0	Attending ir death. ector: After by the fune	atic	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,	М		es 2□No				
Division	ar de	E	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, facto	ry, office			(Street a	and Number or Rur	ral Route Number,
Ö	s afte	Certification;			• • • • • • • • • • • • • • • • • • • •					o, O.u	10)	
	ospi hour uner ly fill		29a. Certifier 1 Certifying Phys	sician: To the best of my knowner: On the basis of examina	owledge, death	occurre	at the time	e, date and place	e, and due to th	e cause(s) and manner as	stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medicai	one)	and manner stated.	ation and/or inv				uned at the tim	e, date ar	no piace, and due t	to trie cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29	c. License	number		29d. D	ate signed (Month,	Day, Year)
	0			7	-		Do	53216	5	/	April 1	3 2006
1	0		30. Name and address of person who co	mpleted cause of death (Ite	т 23а) (Туре, І	Print)	, inter-	()	11 -1	/	7	0.00
-	<u> </u>		DR Tong Jing C	1000 FRANK	In Sa	Na	NO DI	TUR K	saltin	10re	md ?	21237
			31. Date filed (Month, Day, Year)	2006 32. Registrar's Sign	ature	A. Care	30	•				
	State Registrar 31. Date filed (Month. Gar. Fact. 8 2006 32. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 2:00 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10105 Gen Arm
If Under 1 Year | If Under 24 Hrs. Baltimore Ursing Security Number 7. Age (In yrs. ast birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 143 Months Days Hours Min. 1 M 2 F Director renns Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Bent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f show ury or other treumetic svent, Its Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Completed by Funeral Director more 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cupan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Number or Rural Route Number, 19a Informant's Name/Relationship (Type, Print) esa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. `4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Funeral chape Evahs Approximate Interval Between Onset and Death 2 WEEKS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. PHEUMONIA Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying bases or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medicai Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, DEMEN 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a

To the Funerel C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) (2) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) GORALAN MD J 512 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAM AND WOPPLAN MU ZE RILLING

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

WEDSS RABDS

BACTIMORE MA

			1 - For State Registrar		laryland /		tment of F		Mental Hy	ygiene Reg. No. 0 0 6	2 9
	Physic /Medi		1. Decedent's Name (First, Middle, La. Donald Arlin		1				2. Date of D Month	eath //ワークンのも	3. Time of Death 2 30A M
	Examir			arles Vil				timore		4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. S 219-30-8518 2	ex 7. A ☐ M 2 ☐ F	ige (In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	8. Date of Bi (Month, D Feb.		rthplace (State or Foreign ountry) nsylvania
	Maryland e-f show	tor	10a. State 10b. County Maryland	N/A	10c. City, Tow		altimor	e			10d. Inside City Limits XIX Yes 2 ☐ No
	h with the 23a or 28e	Funeral Director	10e. Street and Number 2643 Hampden Aven	iue			10f. Zip Code	21211		10g. Citizen of What C	ountry? USA
9036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show 'a Madical Examiner must be notified at	d by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎛 Worced	12. Was Deceden Armed Forces 1 X Yes 2 If Yes, Give Year or Dates	t Ever in U.S. ?]No : Unknown		is Decedent of H res, specify Cuba	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Noto Rican, etc.)	o- 14. Race - Am Black, Whi	
Baltimore, Maryland 21215-0036	be filed within 72 h tal Hygiene. d other than "natu event, It e Medica	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 11th	lucation de <i>completed)</i> College (1-4or		(Give kir life. DC	nt's Usual Occup nd of work done NOT use retired ance Off	during most of wo		High's Dan	,
yland		To Be	17. Father's Name (First, Middle, Last) Gerry Heyn					Edna	Grace Sr		
e, Mar	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Relationship (19andy Heyn (Sc		15	507 N	lational		Baltimon	per, City or Town, State, re, Maryland	1 21237
timor	Pages nent of ent: If if ury or o		20a. Method of Disposition 1 ☐ Burial Z ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		cremat Crem		4/19	Date / 2006	20c. Location - City or Catonsville	e, Maryland
Bal	Departi Departi Import eny Inj		21. Signal and of Funeral Service Linn	aspenter	-	Bur 363	lame and Address gee-Hen I Falls	ss of Facility SS-Seitz Road	Funeral Baltimon	l Home, Inc. re, Maryland	21211
	Physician /Medical Examiner		23a. Part 1 Enter the disease, or companies, or heart failure. List only disease or condition resulting in death)	a. Col	id the death. Do line.	. 07	P L U	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	cate be executed by sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence						
P.O. Box 68	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2		topic pregnancy ther (specify)			23d. Date of del Month	ivery Day Year
	The faw requires that ate hes been signed b bage 2 should be deta	þ	Part II. Other significant conditions or	entributing to death I	out not resulting in	n the unde	orlying cause give	an in Part I.	1	obacco use contribute to	the cause of death?
	icien: The law re certificate hes be ector, page 2 sho	Completed					Web.		24a. Was autor perfo 1 \(\text{Yes} \)		atopsy findings available completion of cause of
₹	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpati	0 (TED/O		Othe		ath Check only		
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<u>o</u>	death. ctor: Aft y the fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	iy rear) li	njury		(? Yes 2 □ No			
Divis	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, e	jury - At home, fa tc. (Specify)				City or Tou		
	vithin 24 hours a within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	rsician: To the best iner: On the basis of and manner st	examination and	death odd/or invest	curred at the tim tigation, in my op	e, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
)	To To	Σ	29b. Signature and title of certifier	-2.	N	D.	D45			29d. Date signed (Monti	
	10		30. Name and address of person who c	L1 82	21-N	Type, Prin	10 EW	st. B	altin	4/17/06	2/20/
	Sta Registra	re 1	31. Date filed (Month, Day, Year) APR 1 8	2006 - 32. Registr	rar's Signature		ale				

			1 - For State of Maryland / Dep	artment of Health and Mertificate of Death		ene 0 0 6	12120
	Physici	on	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	/Medic		David William Heese, DDS		April 13	, 2006 Year	3:35 PM
	Examir	er	4a. Facility Name (If not institution, give street and number) Gilchrist	4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimor	е
	Funeral Director		5. Social Security Number 218-28-4318 6. Sex 1X M 2 G F 74 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y) June 24,	9. Births	place (State or Foreign of and
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary -f sho	tor	Md. Baltimore 1055 W.	Joppa Rd. #208 1	Towson		1 ☐ Yes 2 💆 No
	h the	Director	10e. Street and Number	10f. Zip Code		. Citizen of What Cour	ntry?
	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show ta Macifeal Exemples must be notified at	al	1055 W. Joppa Rd. #208	21204		USA	
	er dez	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Agned Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White.	
36	rs afte	by F	1 ☐ Never Married 2 Married 1 1 Married 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:			ite
9	2 hou	ted	15. Decedent's Education 16a Dece	edent's Usual Occupation	161	b. Kind of Business/Inc	dustry
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2	led will ygien her th		Elementary/Secondary (0-12) College (1-4or 5+) Dent			Dentistry	
and	ntal H ed otl	Be	17. Father's Name (<i>First, Middle, Last</i>) John Paul Heese	18. Mother's Name Sophia	e (First, Middle, Mai Emma La	iden Sumame) NQ	
Ž	should nd Me mark mark	ို		ing Address (Street and Number or Rura		3	Cadal
S	alth ar 27 is 11 trau			5 W. Joppa Rd. #208			
ore,	es 1 a of He of He litem		20a. Method of Disposition 20b. Place of Dispo			c. Location - City or To	
Ĕ	Pag ment ant: if		4 □ Donation 5 □ Other (Specify) Hilltop 5	Service Co. 4-17-		Towson, Md	•
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "netural; or items 23e or 28e-f show any injury or other traumatic event. It is Micalical Examinar mant be notified at DRGs.		21. Signature of Funeral Servica Licensee	2. Name and Address of Facility RUCK TOWSON FU 1050 YORK Rd.	uneral Ho Towson,	Ma: 11204	
			23a. Part1. Enter the disease, or complicatione that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	or respiratory arrest,		Approximate Interval Between
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	/Medical Examiner		resulting in death) Due to (or as a consequence of):	4,			2 1075
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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X	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	/Mec	IF FEMALE:				
Box	attend for us	Physician/Me	A Descended time of death	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
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J.	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobaco	co use contribute to th	e cause of death?
Vital Records,	w require been sig should b	Completed by	chronic obstructive lung dise	ase, Atrial	1 ☐ Yes	2 0 3 □ Prob	ably 4 Unknown
ပ္ပ	law ra as be	plet	fibrillation		24a. Was an autopsy	24b. Were autop	osy findings available
		Con			performed	l? death?	2□ No
Z	Physician: The lav this certificete has al director, page 2	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death	7		11
<u></u>	Phys r this ral dii	2	1 Inpatient 2 ER/Outpatier		me 5 Residence 28d. Describe how it	6 XOther (Specify	Hospice
<u>0</u>	th. : Afte	it or	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 2 Sa. Date of Injury (Month, Day Year) 1 Accident investigation	Work? M 1 □ Yes 2 □ No	EDG. Describe now i	njury occurred	
DIVISION OF	I or Attending Phy after death. Director: After this i in by the funeral of	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)		28f. Location (Street	t and Number or Rural	Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatted and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, L	Day, Year)
			M Anthony Kily , mo	D25205	A	pril 13	2006
-	$\rho_{x,i}$		30. Name and address of person who completed capse of death (Item 23a) (Type,	Printy D25205 Charles St. Bal	1. 101	7	
	\		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	Charles St. Bal	A. Ma	21204	
	Sta Registra		APR 1 8 2006	a la la la la la la la la la la la la la			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 13, 2006 Year **Physician** 0019 Peter James Italiano /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. | 13 Year | 1949 Birthplace (State or Foreign New York 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ F 56 218-52-3601 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Counts or 28a-f ehow 7 Is marked other than "natural, or items 23a or 28a-f show traumatic event, the Modified at 1 Yes 2 No Baldwin Harford Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21013 2803 Park Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Diagraph Bradley Dist. sales 12 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth eny linjury or other traumatic event 908. Be Conva Bagwell Frances Italiano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 14 St. Andrew Boulevard, Limerick, PA 19406 Victoria Lee/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gdms. 4/19/06 | Fallston, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Defamil Approximate Interval Between Onset and Death Immediate Cause (Final Co years Ischamic Heart **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed i should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Jaliano, Peter #323259 Director à To the Funeral within 24

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 13, 2006 Hec54439 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4BNOTH Are #310 Bel Air MD 21014 Vincent & Giminaro Do 31. Date filed (Month, Day, Year) APR 32. Registar's Signature 8 2006 ORIGINAL

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Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Dorothy Thomaslyn James 04/13/2006 2:52 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Cheverly Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral 1□ M 21 F Days Hours Director 578-58-3493 64 12/18/1941 Georgia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified at Director 1 X Yes 2 No MD P.G. Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12304 Kingsvalley Court Iteme 23a 20721 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Minister of Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Jefferson Myers Pearl Holzendorf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tra googs. Nathaniel James/Husband 12304 Kingsvalley Ct.Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Md Veterans Cem. 04/21/06 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home N. Capitol St. NW Washington, DC 20001 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of Jying, such as cardiac or respiratory arrest, Immediate Cause (Finat disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 4 Unknown Be Completed 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 1 Yes 1 ☐ Yes 2 ☐ No 2 No After this certification funeral director, p 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital 220 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes 1 patient 2 ER/Outpatient 3 DOA ate of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28a. 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 303/8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr.Cheverly, MD 20785 James Catevenis 31. Date filed (Month, Pay Year) 32. Registrar's Signature, State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#8, perFH, \$856 4/2 Waryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year JENKINS ONALD. ARLI 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL - Johns HOPKINS BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth7/31/1968 9. Birthplace (State or Foreign (Month, Day, Veal) 1968 5. Social Security Number 6. Sex Days Hours 1⊠M 2□F 216-78-7766 37 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1630 Cape May Road 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber В. G. 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ronald Lee Jenkins I Ellie Hugel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Jenkins Wife 1630 Cape May Road, Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 20, 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Cther (Specify) Bayview Crematory Baltimore City, MD. 2006 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mueloa en ou 15 months Due to (or as a consequence of): (

Physician /Medical Examiner

Physician

/Medical

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Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 (A)Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🕅 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of dertifier 29c. License number

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Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. death.

> State Registrar

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31. Date filed (Month, Day, Year) APR 1 8 2006

Jenniter



Medice

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 4 **Physician** 12:05p M $1\overline{1}$ 2006 Jackson Elizabeth Nellie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Manor Care N.H. Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Days 1□M 2□F 76 217-24-7801 8-10-29 Md Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore Towson Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or iteme 23s or USA 21286 509 E. Joppa Road death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 € Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Varies Housekeeping 12th grade other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be rmit. Pages 1 and 2 should be fill partment of Health and Mental High creant: If Item 27 is marked other jy injury or other traumatic even Jackson Mamie Washington Arden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5608 Leiden Rd., Baltimore, Md. Joseph Christian Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-19-06 Lansdowne, Md Mt. Zion Cem. permit.
Departri
Importe
any inju 22. Name and Address of Facility Baltimore, Md. 21. Signature of Funeral Service Licenşee March F.H. East 1101 E. North Ave. Lawont 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTES Myocardial **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day signed by the atte in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No 1 🗌 Yes Division of Vital 26. Place of Death | Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature And title of certifier 29c. License number D0061199 April, 17, 2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NOITH Charles ST, Suite 209, Touson MD 21204 Black. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#10f,perFH state of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Anne A. Knabe April 5. 2006 12:50 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore. Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 🕱 F 70 219-32-9948 Director Usual Residence of Decedent 10c. City Town or Location 10d. Inside City Limits 10b County 10a State 28a-f shov treumatic avant, the Medical Examiner must be notified at 1 ♥ Yes 2 No Maryland N/A Baltimore Directo 21231 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 201 ½ S. Madeira Street U.S.A. 238 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 💆 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elizabeth's is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Teacher School 1 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last) Be 2 should be fi and Mental H William Burton Anne Sullens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other tree once. Anne Cottone (daughter) 8005 Redstone Road, Kingsville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 4/18/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Homes Hetam 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVARIAN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner the burial-transit The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 1 ☐ Yes 2**X** No Division of Vital or Attending Physician: After this certification funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Certification: To 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) ţ, 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

DHMH 17 Rev 1/2001

2006

KNABE

ORIGINAL

Amend item#20a-c,perFh,e855.5/9/06 TT State of Maryland / Department of Health and Mental Hygiene () () (6) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 Year Kelly Robert 14 8:50a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1004 Comet Street Baltimore NA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 216-30-7478 69 Yrs. Director 12 - 9 - 35Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show Baltimore X□Yes 2□No Directo NA Md. 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? r than "natural", or Iteme 23a or The Medical Examiner must be 21202 USA 1004 Comet Street death Funeral or iteme 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Varies Laborer . Pages 1 and 2 should be filed w tment of Health and Mental Hygien tent: If Item 27 is marked other ti jury or other traumatic event, ID llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ewell Connie Kelly William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 E. 24th Street, Baltimore, Md. Mary Kelly Wife 21218 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date Creenwount Cenetery Buriar 2 Cremation 3 Removal from State Department o Importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) Owings Mills, Md. Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 ladi E wan March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Na CENCE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Je/-e Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Stree Due to (or as a consequence of): attending physician Physician/Medical Alcoholisa ate has been signed by the attending phys page 2 should be detached for use as the IE EEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate deaun: 1 ☐ Yes 2 ▲ M 1 Yes 2 XNo Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No nours after death.

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filled in by the for 2 Accident investigation 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examitter. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1)002551 and and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1000 EDIT Beltmore an STOPF 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 2006 Registrar

Medical

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Physicia	ın/	Re gistrar 1. Decedent's Name (First, Midd	le,Last)						2. Date of Death	1	3. Time of Death 21:40
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		4a. Facility Name (if not instituted Bon Secour Hospital	n, give street and nu	umber)			wn, or Loc ore City	ation of Death		NA	eaui
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	last birthday)	If Under Months	1	f Under 24Hrs Hours Min			Birthplace (State or Foreig Country)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Dther S 21. Signature of Funeral Service	n 3 Removal in pecify: a Licensee	from State	o. Place of Disposorematory or of Greenmo	sition (Name ther place) ount C Name and A	e of cemete em. ddress of F.H.	ery, 4-2 Facility East	Date 2006 Bali 1101	Baltimote, M E. North	ty or Town, State ore, Md. id. 21202 Ave.
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Records, The law requir cate has been a	Completed by								24a. Was autop perfo 1 Yes	rmed? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the brown the page of the p	To Be		Hospital: 1	Inpatient 2 te of Injury hth, Day, Year)	ER/Dutpatier 28b. Time of	nt 3 D	OA Ot Bc. Injury a		ing Home 5	Residence 6 how injury occurred	Dther:
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Co		y)	t home, farm, str				or Town, S	itate)	or Rural Route Number, City
Di To the Hospital within 24 hours To the Funeral	Medical	(Check only one) 2 Medical Ex	Physician: 10 the basi caminer:Dn the basi and manner	s of examination	n and/or investig	ation, in my	opinion, o	death occurred	at the time, date	and place, and du	e to the cause(s)
6 ₩ 6	Me	29b. Signature and title of certi		sialeu.		29c	License r	number		29d Date signed	(Month, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AFRIL **Physician** 2006 134 12:30 PM Keplinger Trudy Bernice /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F Country) April 23, 1935 New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2∏F Director 218-38-4989 70 Usual Residence of Decedent be filed within 72 hours after deeth with the Maryland hall Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland <u>Baltimore</u> Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13519 Jarrettsville Pike 21131 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 n/a Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Heelth and Mental H tant: If Item 27 Is marked ott Be Frederick Pike James Elizabeth MacFarland Haze1 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin P. Keplinger, Sr./Husband 13519 Jarrettsville Pike, Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 4/17/06 1 XBurial 2 Cremation 3 Removal from State Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns. Timonium, Maryland 21 Signature of Fune all Service License 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Entry the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of eart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Jause (Fil al disease or condition resulting in death) ENDUMONIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 No 3 Probably 4 Unknown ISCHEMIC CARDIOMYOPATHY Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL INSUFFICIENCY has perfori certificete 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA မ this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 i Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number April 13, 2006 J. Helou, M. D D ØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH J. HELOU M. D. 7601 OSLER DRIVE TOWSON, MARYLAN 3 374- 52 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year 49 **Physician** KINO AM) un e 2006 ocil /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins
5. Social Security Number Bayview baltmore Care Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months Hours 179-20-5932 1 M 2 F Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ŏ 10 items 23a Funerai 12. Was Decedent Ever in U.S. Amed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Dop imment of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or item any injury or other treumatic event, the Medical Evalu 1 Never Married 2 Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OTORS 12×3 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 94TO. CITY DONT (REMATOR) * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 16924 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician percapnea minute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Ver b ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Spinou SULA 2□ No 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

William

31. Date filed (Month, Day, Year)

APR 1 8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenoua

TIL

82 Registrar's Signature

n

MD

04383

5505 Hopkins Bayview Circ

21224

Division of Vital Records, P.O. Box 68760,

Sta Regist DHMH 16 Rev 6/95

Physici /Medi Examir

Funeral Director

		State of Ma	ryland / Dep <i>Ce</i>	ertificate of		-	giene Reg. No.	6	2130
an cal	Decedent's Name (First, Middle, Last) KENNETH			KORNF		2. Date of De Month.	14 2	Year	3. Time of Death 11: 5897
er	4e. Fecility Name (If not institution, give structure) ROLAND PARK PLAC 5. Social Security Number 6. Sex	CE 7. Age	(In yrs. last birthday	/) If Under 1 Yea		MORE			N/A place (State or Foreign
	Usual Residence of Decedent	1 2□ F	90 Yrs.		Hours Will.	MÄR. 11	, 1916		Od. Inside City Limits
ector	MD 10b. County		•	TIMORE					1 X Yes 2 □ No
rai Dir	830 W. 40TH STREET			10f. Zip Code	21211		10g. Citizen of		USA
Completed by Funeral Director	11. Marital Status 12. Never Married 2 M Married 3 Widowed 4 Divorced	Was Decedent Every Armed Forces? 1 XX Yes 2 □ Note of Yes, Give Year or Dates:	ver in U,S.	. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🛱 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes of No o Rican, etc.)	Bla Specif	ck, White,	ean Indian, etc. WHITE
ompieted	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ion ompleted) College (1-4or 5+	(Giv	edent's Usual Occi re kind of work don DO NOT use retir TIST	ipation e during most of woi ed)	rking	16b. Kind of B	usiness/In	dustry
B B	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle	, Maiden Surnar	ne)	DETCH
2	HERMAN	D-2-4)	KORNR		SADIE	ural Route Numb	or City or Town	State Zin	REICH
	19a. Informant's Name/Relationship (Type: JEANNE KORNRICH /	wife			STREET #				
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery, cr		ece)	Date 4/16/06	20c. Location		own, State
	21. Signature of Funeral Service Licensee			22. Name and Add		OL LEVIN			
	23a. Part1. For the interpretation as each of complication of the state of the stat				ring, such as cerdiad	or respiratory a	rrest,	1	Approximate Interval Between Onset end Death
	Immediate Ceuse (Finel disease or condition resulting in death)	Ischen	ue to (or es e conse	Lionys	athy			!	Years
ē.	resulting in death)	Paran	oue to (or es e conse	equence off:	111222			E E	Years
Examiner	Sequentially list conditions,	D	ue todor es e conse	equence of):	roce de				
edicai E	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D	ue to (or as e conse	equence of):					
M/u	L d.								
ysicia	Pert II. Other significant conditions contril		_			23b. Dld	tobacco use co	ntribute t	o the cause of death?
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Be Completed by Physician/M	maker placement						en autopsy ormed?	av	ere eutopsy findings eileble prior to impletion of cause death?
Com						1 🗆 '	Yes 21 No	1[□Yes 2□No
o Be	25. Was case referred to medicel examiner?	pital: 1 ☐ Inpetien	t 2 ER/Outpetie	ent 3 DOA	thor:	ath <i>(Check only o</i> Iome 5 ☐ Resi		ner (Specia	fv)
Comparison Com								7	
Certific	3 Suicide 6 Could not be determined	28e. Plece of Injur building, etc.	y - At home, farm, s (Specify)	street, factory, office	•	28f. Location (City or To	Street and Numi wn, State)	ber or Rur	al Route Number,
dicai	29a. Certifier (Check only one)		examination and/or i						
29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Yee, D/3657 Dful 14, 2096									
	30. Name and eddress of person who composite the state of	pleted cause of dea	ath (Item 23a) (Type 700 W - 4	e, Print) DYL STR	ET, BALT				100
ite ar	31. Date filed (Month, Day, Year) , -	32. Registrar	's Signature	hours					

			State of Maryland / Department of Health and 1- State State Certificate of Death	Mental Hy	/giene)6	12131
	a a		1. Decedent's Name (First, Middle, Last)	2. Date of D	eath		3. Time of Death
	Physici /Medic		Mildred L. Kacher	Month	Day	Year	6:30 P M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea	th	-	ity of Death	
		W -	Franklin Square Hospital HOSEdal	E	Bo	7	MORE
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 87 Yrs. Months Days Hours Min		irth Jay Year)	9. Birth	olace (State or Foreign ntry) ryland
113	Director		217-07-6910 Usual Residence of Decedent	07 02	1710	, iid.	Lyzana
1	yland how		10a. State 10b. County 10c. City, Town or Location			1	10d. Inside City Limits
	Ba-f e	cto	MD Baltimore Perry Hall				1 □ Yes 2 No
18	with the	Dire	10e. Street and Number 10f. Zip Code 21236		10g. Citizen o	i What Coul	ntry?
I dre	within 72 hours after death with the Maryland ane than "natural", or itama 23a or 28a-f ehow the Modical Espoilmet is all be notified at	Funeral Director	12 Was Decedant Ever in U.S. 12 Was Decedant of Hispania Origins //	Specify Yes or N		ace - Americ	can Indian.
00	ifter d	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puel	rto Rican, etc.)	В	lack, White,	
, _ SO	ours a	d by	3 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Spec	ify: WII.	
7 5	natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work (iffe. DO NOT use retired)	orking	16b. Kind of	Business/In	dustry
121	withir ene. than	Jup	Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker		Own ho	me	
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lan \lesssim	uld be Aenta rked tic av	To B	Irvin Ludloff Helen S	Strasshe	im		
h ER	2 sho and h la ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R			n, State, Zip 11236	Code)
(-)	and lealth m 27		Charleen Hecker/Daughter 9436 Bellhall Dr., Per	Date Date			0.11
Ka.(permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f ehow any injury or other traumatic avant, the Modical Exportment countilities at an		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		20c. Location		
- <u>Z</u> =	if. Partmer		4 ☐ Ponation 5 ☐ Other (Specify) Gardens of Faith Cem. 04- 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility M.		Baltimo		
Ba	Depa Impo any it		6415 Belair Rd.,				
9.4			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition as Left Middle CEREBRAL AR			2+	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		D11 1004		
	LAGITITICI	70	Sequentially list conditions, b. If any leaging to immediate Due to (or as a consequence of).				
	uted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
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9	artifica ing ph e as th	Med	IF FEMALE:				
90°	ath ce	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			Date of delive Month	ery D <i>a</i> y Year
Ö	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify)				
م َ	es that the death certifi Igned by the attending. be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use co	ntribute to t	he cause of death?
rds	w requires been slg should be			1 🗆	Yes 2 No	3 🗆 Prot	ably 4 □Unknown
o O	e law requ has been je 2 should	Completed		24a. Wa	s an 24b	. Were auto	opsy findings available impletion of cause of
Ä	The I	Com		per 1 ☐ Yes	formed?	death?	
/ita	ilclan: The certificate rector, pag	Be	examiner?	ath (Check only	one)		
ot	ding Physician: n. After this certific funeral director,	. To	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 ☐ Res	how injury occ	1-7-	(y)
on	Attending Physician: The law requires that the death certificaeth. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	tion	1 ☑ Natural 5 ☐ Pending (Month, Ďay Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No				
Division of Vital Records, P.O. Box	l or Attendi after death. Director: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Street and Nur.	nber or Rura	al Route Number,
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	To the Hospital or Attenwihin 24 hours after deall To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the time	e cause(s) and r	nanner as s and due to	tated. o the cause(s)
	o the ithin 2 o the emple	Med	29b. Signature and title of certifier. 29c. License number		29d. Date sign	ned (Month,	Day, Year)
	C = 3 = 8		Mikloulo REGION		4/12	106	
	1		30. Name and address of person who completed cause of feath (Item 23a) (Type, Print)			1 - 43	
	(30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) APR 1 8 2006	Balt	more,	MD	31837
de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature		'		
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APR 1 8 2006 DHMH 17 Rev 1/2001

			1 - State Registrar	State of Maryland		irtment of H tificate of i			giene leg. Ne. 006	12132
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici		CLAUDE HOWARD	LAMB, SR.				APRIL	17, 2006	3:28 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give str			4b. City, Town, or	Location of Death		4c. County of Dea	
			918 N. AUGUSTA AV	JENUE		BALTIM	ORE			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bit	thplace (State or Foreign ountry)
	Director		217-34-3000 ^{1🛛}	^{M 2□ F} 75	Yrs.	Widitins Days	Tiours ivins.	2-26-	1931	NC
	2		Usual Residence of Decedent	140-07-	T					Log beide die tiede
-	show	_	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
	Ba-f.	ç	MD	BA1	LTIMOR	Ę				
3	9 2	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a	<u>a</u>	918 N. AUGUSTA AV	JENUE		212			USA	
		Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
ဂ္ဂ	or it		1 Never Married 2XXMarried	1 X Yes 2 □ No If Yes, Give	1	☐ Yes 2🌠 No	Specify:		Specify:	
000	within 72 hours affer death with the Maryland ene. Than "natural", or itema 23e or 28e-f show ha Medical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	10. 5		-41	F		LACK
r i	"nat	Completed	15. Decedent's Educa (Specify only highest grade		(Give	lent's Usual Occup kind of work done OO NOT use retired	during most of wor	king	16b. Kind of Business	vindustry
7	Mithig Pan Pan Mithigan	Ē	Elementary/Secondary (0-12)	College (1-4or 5+)					LAW ENFO	DCEMENT
י מ	be filed within 72 hours after death with the Maryla lat Hygiene. d other than "natural", or flema 23a or 28a-f shov event, the Medical Examinating the notified at	e Co	17. Father's Name (First, Middle, Last)	2	PUL	ICE OFFI		ne (First, Middle,	Maiden Sumame)	KCEMEN I
	o d o	00	JOHN THOMAS LAMB				BFATR.	ICE JONE:	S	
آ ج	should be ind Mental in marked o	ဥ	19a, Informant's Name/Relationship (Type	e Print)	19h Mailin	n Address (Street			r. City or Town, State.	Zin Code)
20	12 si han 7 ts r traur	r i	BERTHA LAMB/WIFE	o, <i>Francy</i>		N. AUGUS		BALTIMO		229
a)	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of		Date	20c. Location - City o	r Town, State
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	rtant rtant		4 □ Donation 5 □ Other (Specify)				7.7	22-06	BURGAW,	
Dalt	permit. Pages Department of I Important: if ite ony injury or of		21. Signature of Funeral Service Licenses	m A						NS F.H., INC.
	402 0 0		James 9.	forcon		701-31 L				YLAND 21217 Approximate
			23a. Part Enter the disease, or complice shock, or heart failure. List only one	cause on each line.		•				Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	METAST	ATIC	, thros	TATE (ARCIA	JOMA	51X YEARS
•	/Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):					•
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8	physi the t	dlcal	d .					***		
٥ ×	death certificate e attending phys d for use as the	an/Me	IF FEMALE:	c. If yes, outcome of pregnar	ıcv				22d Date of de	, G
X Q Q	ath c attend	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal	death 3□	Ectopic pregnancy	1		23d. Date of de Month	Day Year
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<u>.</u>	requires that the neen signed by th hould be detache	유	Part II. Other significant conditions cont	ributing to death but not resu	ting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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ecord	w require been si should t	Completed								
ခ	law nasb e2s	d						24a. Was autop	an 24b. Were a prior to death?	utopsy findings available completion of cause of
	sician: The law certificate has b irector, page 2 s	S						perfor 1 ☐ Yes	2 1 Ye	
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?			1011		ath (Check only or	ne)	
	ک اقام	2	10 105		R/Outpatien		4 Nursing F		lence 6 Other (Sp.	ecify)
_	Ing P	0	27. Mann 1 Death 1 1 atural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe h	low injury occurred	
DIVISION OF	tal or Attending Pissafter death. al Director: After the ed in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
≥	or At after d Direct in by	E	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str)	eet, factory, office		City or Tow	Street and Number or F m. State)	fural Houte Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in								· · · · · · · · · · · · · · · · · · ·	
	Hosp 4 ho Fune ely fi	ca	(Check out) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati	vledge, death ion and/or inv	noccurred at the tire vestigation, in my o	me, date and place pinion, death occu	e, and due to the our arred at the time, o	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b Signature and title of certifier	and manner stated.		29c. Licens	e number		29d. Date signed (Mor	oth Day Year!
	1 v C		230: Signature and the of Certiner	1		A C	N C10 12		AP211	7 2006
•				/		LDO	031)4	6	117,0	1, 2000
	1.+1		30 Name and a dress of person who con ROBENTO PILI TO	Impleted cause of leath (Item	23a) (Type.	Print)	2001	10 00 1	24.5.4.	- 4 4 3
	4		21 Date filed (Month Day Year)	TAN HOLKINS	HOUP	14T 107	OKLEAN	VJ _ J7. L	SALITORI	וצוע עוויג
	Sta Regist	ate	31. Date filed (Month, Day, Year) APR 1 0 2000	32 Registrar's Signat	ure .	_ ^				

DHMH 17 Rev 1/2001

ORIGINAL

ath Day Year 3. Time of Death 17 2006 01:05 PM 4c. County of Death NI / A				
4c. County of Death				
N/A				
B. Date of Birth (State or Foreign (Month, Day, Year) (Month, Day, 1938 Maryland				
0,1938 Maryland				
10d. Inside City Limits				
1 ✓ Yes 2 □ No				
10g. Citizen of What Country?				
U.S.A.				
14. Race - American Indian, Black, White, etc. Specify: White				
16b. Kind of Business/Industry				
Home				
Maiden Sumame)				
artline				
or, City or Town, State, Zip Code) ore, Maryland 21230				
20c. Location - City or Town, State Baltimore, Maryland				
Home P.A. more, Maryland 21230				
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23d. Date of delivery Month Day Year				
obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No				
one)				
dence 6 Other (Specify)				
Street and Number or Rural Route Number, vn, State)				
causa(s) and manner as stated, date and place, and due to the cause(s)				
29d. Date signed (Month, Day, Year)				
april 17, 2006				
Baltimore MD 2128				
Baltimore, MD 21235				
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2006 **Physician** Alice Florence Lieberman April 12:46 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Ye Dec. 29, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year, 1 ☐ M 2 💢 F 94 071-22-5425 1911 New Jersey Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20852 United States 6111 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: White þ 3 ₹ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than . Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other sny injury or other trainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sadie Hecht Emil Ullman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 A Street, N.E., Washington, D.C. Sylvia Nolde / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State April 16, ' 4 ☐ Donation 5 ☐ Other (Specify) Hebrew Cemetery Charlottesville, Virginia 2006 21. Signature of Funeral Service L 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Numb MAIN M01420 7557 Wisconsin Avenue, bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMIC CARDIOMOPATHY Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physicien Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths? Month Day Year 4 Pregnant at time of death 5 Other (specify) cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No Certification: To Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: / completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, elli 30. Name and address of person who completed cause of death (Item 23a) (Type; Print) MONTRO. (N55H 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

		·	For State Registrer	State	of Marylar	-	rtment <i>tificate</i>		ealth and M Death	lental H	ygiene Reg. No	'Ullh	12135		
	Physici	an.	1. Decedent's Name (First, Middle	e, Last)			McGI			2. Date of D Month	Death Day	y Year	3. Time of Death		
	/Medic		Eileen							April	12	2006	18:21 PM		
-	Examin	er	4a. Facility Name (If not institution The John Hupkin				Ball		Location of Death		4c. County of Death				
	Funeral		5. Social Security Number Jn K.		7. Age (In yrs.	. last birthday)	If Under 1	1 Year	If Under 24 Hrs.	8. Date of B	lirth	9. Birth	place (State or Foreign		
	Director			1□M 2 X)F	64	Yrs.	Months	Days	Hours Min.	03/27	7/194	2 Cou	NY		
	pur &		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	cation						10d. Inside City Limits		
	Maryla f eho	٥	MD			TIMORE							1 X Yes 2 □ No		
	28a-	Director	10e. Street and Number				10f. Zip (Code			10g. Cit	izen of What Cou	ntry?		
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Mar	2 kg as 12		DENNIS MCGRAW				•		PARK, DOI						
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Baltimore,	permit. Pages 1 Department of H Important: If Ite eny Injury or ot once.		21. Signature of Funeral Service	Licensee	D		. Name and						NS FH, IN		
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7	Physician /Medical		disease or condition resulting in death)	a. Post	erior (OMMUN	catin	9 0	nted	strok	۷		3 months		
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	To th within To th comp	Me	29b. Signature and title of certifie	or			29c.	License	number		29d. Da	te signed (Month,	Day, Year)		
			holis Lon	-6	MD PI			Re	s-000)	Apo	1 /2	2606		
	2		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	0		A					
24		10	Julie Lolman 31. Date filed (Month, Day, Year)	600 No	Registrar's Sign	Ac the	et, h	a11	more 1	Mary 10	ind	21287	_		
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		1 - For State Registrar	State of M	Maryland		artment of Hertificate of L		d Mental Hyg	giene) (6	12136			
	*	1. Decedent's Name (First, Middle, Last)			-			2. Date of Dea Month	th Day	Year	3. Time of Death			
Physicia /Medic		Jean Marie Mal	.i					April	15,	2006	4:25 A™			
Examin		4a. Facility Name (If not institution, give s				4b. City, Town, or		eath	4c. Count					
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Funeral	-0	5. Social Security Number 6. Sex	M 2X7 F	Age (In yrs. id		If Under 1 Year Months Days	If Under 24 h	Ain. (Month, Day	(, Year)	9. Birtho	lace (State or Foreign htry)			
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and **		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits			
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r 28e	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?			
h with	Funeral Directo	850 Meadow Heights	}			21012			US	SA				
deat	ner		2. Was Decede Armed Force		S. 13.	Was Decedent of His	spanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Ra	ce - Americ				
or Its	F	1 Never Married 2 Married	1 Yes 2 If Yes, Give		4	1 ☐ Yes 2 💢 No	Specify:	derito ritodri, etc.,	Specia		_			
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17215-0036 within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28e-f show the Madical Examination at the motified at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of	working	16b. Kind of E	lusiness/Ind	Justry			
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md 2 alth a 27 l		Michael E. Mali, S	Son		850 1	Meadow He:	i hts	Arnold, M	laryland	1 2101	L2			
of He		20a. Method of Disposition	amount from Cto	20b. Pl	lace of Dispo	sition (Name of natory or other place	9)	Date	20c. Location	- City or To	wn, State			
Page nent nent ury o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval nom Sta	Men	eadowr: ioriaI	natory or other place idee Park	04	4/19/06	Elkric	ige, N	Maryland			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or Items 23a or 28e-1 show any injury or other treumatic event, tra Madical Examinational benefitted at once.		21. Signature of Funeral Service License Thomas Gregor	-yy		M2 30	2. Name and Address acNabb Fui D1 Freder:	s of Facility neral I ick Roa	Home P.A. ad Catonsv	ille. N	Marvla	and 21228			
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Division of Vital Records, to Attending Physician: The law requires that death. Director: After this certificate hes been signs in by the funeral director, page 2 should be.	Completed							24a. Was autop	sy	prior to co death?	psy findings available impletion of cause of			
Vital F vicien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check only o						
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Division of Vital Revision of Vital Revision of Vital Revision 24 hours after death. To the Eunerel Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 Surcide 6 Could not be 4 Homicide determined		Injury - At ho etc. (Specify		eet, factory, office		28f. Location (S City or Tow		ber or Rura	ll Route Number,			
To the Hospitel within 24 hours and to the Funerel completely filled	edical	29a. Certifier (Check only one) 16 Certifying Phys 2 Medical Examin	ician: To the be ier: On the basis and manner	s of examinat	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and pointion, death o	lace, and due to the o occurred at the time, o	cause(s) and m date and place	anner as si and due to	tated. the cause(s)			
To the within To the comp	M	29b. Signature and title of certifier	1 1			29c. License			29d. Date sign	•				
		1 / milleu	alla	en in	9	D311	36)	APRIL	17.	2006			
5		30. Name and address of person who co	LCACE	mi	5,90	Print) 205 KI	LBR	DE RD	BALTIN	ushe	mp 2136			
Sta Registr		31. Date filed (Month, Day, Year) APR 1 8 200	93	istrar's Signa	ture da	adi)		/						

DHMH 17 Rev 1/2001

ORIGINAL

06-0243	3
Merrick.	Eldora

Please Type or Print in Black Indelible Ink

rrick, Eldora		S1 1- For State Registrar	ate of Maryl		artment of rtificate of		and N	/lental Hy	/giene	Reg No. 2	006	213
Physicia dical Exami		Decedent's Name (First, Midd	_{e,Last)} Merrick						2. Date of De Month April 9, 2	Day Y	ear	3. Time of Death 14:00
1		4a. Facility Name (if not institution 1221 W. North Avenue	· -	umber)	4	b. City, Town, Baltimore		ation of Death		4c. Count	y of Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		f Under 24Hrs. Hours Min.	8. Date of I	Birth (MM/DD/YY)	YY) 9. Birth Coul	iplace (State or Foreig
Director		218-64-0549 Usual Residence of Decedent	1 M 2 X F		50 Yrs.	World's	Jays	Trodis TVIIII.	July	5, 1955	Man	cyland
id how any Ee.	L	10a. State 10b. County	'A	10c. City	, Town or Location Baltin							10d. Inside City Limits 1 XYes 2 No
Marylan 28a-f s d at on	Director	Maryland 10e. Street and Number		1	Darci	10f. Zip Cod	е			10g. Citizen of V	Vhat Count	ry?
5-0036 ed within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Funeral		arried 12. Was De Armed F 1 Yes rorced If Yes, Give Ye	cedent Ever in U forces? 2 X No	If Ye	Decedent of	ban, Me	ic Origin? (Sp exican, Puerto l			ite, etc.	an Indian, Black,
72 hours af n "natural" al Examin	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)	or Dates: cify only highest gra		16a. Decedent		pation (Give kind of w	ork done	16b. Kind of E		
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Heatth and Mental Hygiene. nt: If item 27 is marked other than ' other traumatic event, the Medical	Be Compl	12 17. Father's Name (First, Middle Robert Merrick			Clerk	-	18.M			Groce, Maiden Surnam		core
MD 212 d 2 should b Ith and Ment n 27 is mark	To E	19a. Informant's Name/Relations Ellen Merrick,	hip (Type, Print)		_		treet an	d Number or R	ural Route N	umber, City or To e, MD 21 20c. Location		
Baltimore, oermit. Pages I and Department of Heal Important: If item injury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S		from State	Place of Disposit crematory or other crematory or other crematory or other crematory or other cremators or o	er place)			Date /13/06			own, State Maryland
		21. Signature of Funeral Service Thomas Gregor 23a. Part I. Enter the disease, or	Licensee		22 N	ame and Addr	ass of F	acility			•	-
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Comp1: Due to (or as		of chronic			ras cardiac or	respiratory a	1165t, 310ck, 0111	cart	Between Onset and Death
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in of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate E. After this certificate has been signed by the attending physicianeral director, page 2 should be detached for use as the bu	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Un	1 Live	nant at time of de	2 Fet	al death er <i>(Specify)</i>	3E	ctopic pregnat	ncy	23d. Date of Month	of delivery Da	ay Y ear
P.O. I res that the signed by the be detached	ģ	Part II. Other significant condit	ions contributing	to death but not r	resulting in the ur	nderlying caus	se given	in Part I.		tobacco use con		ne cause of death?
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Cou	d not be rmined (Specify		ome, farm, street	t, factory, offic	e buildi	ng, etc.	28f. Location or Town,		ber or Rura	Il Route Number, City
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		30. Name and address of person Patricia Aronica-Polla		ise of death (Item tant Medical		111 Penn	Stree	t, Baltimore	e, MD 212	01		
St Regist	ate tra r	31. Date filed (Month, Day, Year)	8 2006 32.R	egarar's Signatu	ure A	ack)						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear EBORA **Physician** HEWS April 105 2006 1.2 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPI BALTIMORE ENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 🗐 🤊 47 216-82-1793 Usual Residence of Decedent Yrs. February 13, 1959 Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "naturel", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 Tes 2 No Be Completed by Funeral Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 106 Seag 21225 Avenue VII 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Btack, White, etc. 1 ☐ Yes 2 W No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SEL HOUSEWIFE permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gloria George Lomax 2 E. Graves, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sidney Avenue, Baltimore MD 21230 2110 Valenie 1 - raves 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery April 20,2006 Lansdowne, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Acility Harris P. 105E Fun exal Service, P.A. 5126 Belave Road, Baltmare MD 21206 21. Signature of Fulleral Sep Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ESPIRATORY FAILURE Pnysician one day /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) the 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 MNo 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral 6 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Xiaoguanz MD RESOOO Jun

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 1 8 2006

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XIAOGUANG SUN, 3col S. HANOVER ST. BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #5,10a-f Per Inf G8 Sertificate of Depath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Joseph L. McManus 15, 9:45 P M April 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

July 12, 19 Stella Maris Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 217-25-0040 217-26-0040 Usual Residence of Decedent 1**X**IM 2□ F Months Days Yrs. Director 76 1929 Maryland Florida St.Lucie 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Items 23a or 28a-f ehow 1 ☐ Yes 2 ☑ No Director Mary land Baltimore Fimonium Port St. Lucie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6443 NW Fontana St. 21093 34986 18 Lovet# Court USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Roman Catholic Priest Religion other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James I. McManus Mary T. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 leany Injury or other train 2005. Miss Mary J. McManus (Sister) 18 Lovett Court Timonium, Maryland 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4/20/2006 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. Towson Maryland 21. Signature of Jun rail erviced 22. Name and Address of Facility 21204 Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): anding physicien and use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical After this certificete has been signed by the ettending I funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to that hot not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 47065 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 2 10 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Matural 5 Pending death. investigation 1 Tes 2 No Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours efter d filled in by 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner? On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15504

Registrar

State

10

2006

MCMANUS

31. Date filed (Month, Day, Year)

EDDIE NAKHUDA, M.D.

8 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

21093

TIMONIUM, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#17,perFH_C354_/18/06_TT
Department of Health and Mental Hygiene And Copies Are Legible.

			For State Registrar	State of Marylan	_	tificate of			eg. No.	12140				
	Physici	an	Decedent's Name (First, Middle, Las JUDITH	it)		MILLER		2. Date of Deat APRIL	1 ^D 4 ^y 2006	3. Time of Death 9:00 A M				
j.	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat		4c. County of D	eath				
			2721 WOODCOURT RC 5. Social Security Number 6. Se		last hirthdau	BAL If Under 1 Year	TIMORE	8. Date of Birth		TIMORE				
	Funeral Director		212-50-3410	D M 2√ F 59	Yrs.	Months Days	Hours Min.		946	Birthptace (State or Foreign Country) MD				
	e Maryland ta-f ehow	ctor	Usuat Residence of Decedent 10a. State 10b. County MD BALTI		y, Town or Lo			-		10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	th with th	Funeral Director	10e. Street and Number 2721 WOODCOURT F	ROAD		10f. Zip Code 21209		1	0g. Citizen of What U.S.	•				
920	within 72 hours after death with the Maryland one. than "natural", or itame 23a or 28a-1 show in Modical Executor roast be notified at	Ď	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2☐XNo	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, W	merican Indian, hite, etc. WHITE				
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212	ed with giene.	Com	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	TEACH	ER			EDUCA	TION				
land	should be fill and Mental Hy s marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) THEODORE		K	lein LINE	18. Mother's Name (First, Middle, Maiden Surname) MAHSEE HOCHBERG							
Maryland 21215-0036	nd 2 shot alth and N 27 is mai		19a. Informant's Name/Relationship (7 STEVE MILLER / HUS	• • • • • • • • • • • • • • • • • • • •					RE, MD 21					
Baltimore,	Pages 1 a ent of Hee nt: If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crer	sition (Name of natory or other place HEBREW		15	20c. Location - City EISTERSTO					
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dependent of Heelth and Mental Hygiene. Dependent of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or itame 23e or 28a-1 ehow on any injury or other traumatic event, it a Medical Examinar must be notified as once.		21. Signature of Funeral Service kinen	SON & BRO										
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic Breast Cancer												
			resulting in death)	Due to (or as a conseq				-		- Jyes				
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Σ	F # F C	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y) 			City or Town	n, State)	Rural Route Number,				
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	To t withi To th	Σ	29b. Signature and title of certifier	an Oncologist		29c. Licens	e number 756 919	2	9d. Date signed (M6	onth, Day, Year)				
	15		30. Name and address of person wh	empteted cause of death (Item		Print)	Medi	Cal Ca	04/15/ enter					
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8 20	32 Registrar's Signa	ture a	Al More	, , , , , ,		,,,,,,					
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DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan		artment o			nd Me	ental Hygi	ene g. No. 0 0 1		12141
	W)		Decedent's Name (First, Middle, I	Last)						2	2. Date of Death	1	<i></i>	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, o			-	4b. City, Tox	wn, or Lo	ocation of			4c. County of		
, .			UNIVERSITY OF M.	AMLAND			BARN	Mar	1/2			BAUTI	nouv	2 CITY
7	Funeral		5. Social Security Number 6		. Age (In yrs.		If Under 1 Y Months D		If Under 2 Hours	Min. 8	B. Date of Birth Month, Day, JULY 15	Year)	. Birthpl Coun	lace (State or Foreign try)
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	land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
	Mary -f she	ţŏ	MD N/A	1		BALTI	MORE							1 Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Co	ode			10	g. Citizen of Wh	at Coun	try?
	h with		4410-J FALLS BF	RIDGE DRIV	'E				2121	11				USA
	eme .	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	.S. 13.	Was Deceden	t of Hisp Cuban.	anic Orig	in? (Speci	fy Yes or No- ican, etc.)	14. Race -	America White,	
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	and 2 lealth m 27 i		JOSEPH O'NEIL /	LEGAL GUA					3RID0			ALTIMORE		
ore	0 0		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3	□Removal from SI	ate C	emetery, crer	sition (Name in matory or other	r place)	1	Dat	_	0c. Location - Ci		
altimore,	Pages ment of ant: if its ury or o		4 Donation 5 Other (Spe	city)	MD						/2006			LLS, MD
Ball	permit. Pag Department Important: i eny in ury o		21. Sign that of Juneral Service Li	Ling	m							N & BROS KESVILLE		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that can	used the deat									Approximate Interval Between
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387	the the	dlcal		d.										
Box	death certific e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d. Date of	of delive	ry
ň	death e atte	clai	in the past 12 months?	4□Pregna	h 2□Feta nt at time of d]Ectopic pregr] Other (s <i>peci</i> i					Month		Day Year
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ğ	w require been sig should b									_	1 🗆 Yes	s 2□No 3	☐ Prob	ably 4 Unknown
Vital Records,		Completed									24a. Was an autopsy	24b. We	re autop	psy findings available inpletion of cause of
<u> </u>	The ate h page	Son									perform	ed? dea	ith?	2 No
īta	cien: artific actor,	Be (25. Was case referred to medical examiner?					2	26. Place	of Death (Check only one)		
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Ę	ing P	on:	27. Manner of Death 1 ANatural 5 ☐ Pending		Day Year)	28b. Time of Injury		Injury a Work?		İ	ld. Describe how	w injury occurred		
S	death death tor: , the f	lcat	Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be 200 Bloom	f Injuny At h	omo form etc	M		s 2 N		of Location (Str	eet and Number	or Pura	I Boute Number
Division of	after Direction by	Certification:	4 ☐ Homicide determin	ed building	, etc. (Specif	y)	eet, factory, o	ince		20	City or Town,		or nura.	r Houle Warnber,
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge, deatl	h occurred at t	the time.	, date and	d place, an	d due to the car	use(s) and mann	er as st	ated.
	e Fur letely	edical		caminer: On the bas	is of examina	tion and/or in	vestigation, in	my opin	nion, deat	h occurred	at the time, da	te and place, and	d due to	the cause(s)
	withir To th	Me	29b. Signature and title of certifier				29c. L	icense r	number		29	d. Date signed (Month, I	Day, Year)
			1/1/	L ABR	CARRETT	C. M	/	019	64	5		4/13/	06	
-	10		30. Name and address of person w			n 23a) (Type,	Print)						2	
	1		MICOTAGE	ABRAHAS		27.56	LEGINE		5	BANT	mure	MO	61	201
	Sta		31. Date filed (Month, Day, Yeal)		gistrar's Signa	ature	A							
. *	Registr	ar	APR 1 8	2006 /	yes f	1 Sol	Me							

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		f Maryland /		artment of			F	Reg. No.) 6	2142
	Physici	an	Decedent's Name (First, Midd Elmer Hammond							2. Date of Dea	Dav	2 CCV	3. Time of Death
	/Medio		4a. Facility Name (If not institution		nber)		4b. City, Tow	n, or Locatio	n of Death	AN EN L	_, _ ,	nty of Death	J
1			Baltimore Wash					Burn				nne Ar	
	Funeral Director		5. Social Security Number 218-14-5478	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs. last 83	birthday) Yrs.	Months Da		er 24 Hrs. Min.	8. Date of Birti Month, Day June 1:	ı. Year)	Cou	place (State or Foreign ntry) /land
	ס		Usual Residence of Decedent							Julie 1.	1,1722		
	arylan show	2	10a. State 10b. County		10c. City, To			1 .					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	recto	Maryland Anne	e Arundel	Lin	ithic	um Heig				10g. Citizen	of What Cou	
	h with	al Di	112 Homewood Ro	oad			210				US		70
	r deat	Iner	11. Marital Status	Armed For	dent Ever in U.S.	13.	Was Decedent	of Hispanic (Juban, Mexic	Origin? (Spe can, Puerto F	cify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,	
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	w requires that the deben signed by the should be detached	۵	Part II. Other significant condit	i ons contributing to de	eath but not resultin	g in the u	nderlying cause	given in Pa	rt I.	23e. Did to			the cause of death? bably 4 llnknown
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	To the Hospital or At within 24 hours after or To the Funarel Direct completely filled in by	edical C		ing Physician: To the i Examiner. On the ba and mann	asis of examination								
	To the within To the compl	Me	29b. Signature and title of certifi	ər			29c. Lic	ense numbe	er -		29d. Date siç	gned (Month,	Day, Year)
	A		1 that the		M		O	1397	7	1	John	- 14	P 2006
1	DXI		30 Name and addr. s of person	n who completed caus	e of death (Item 23	a) (Type,	Print)	[.1.	. 1	ime	m	211	061
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06-02528 Edward Opher Please Type or Print in Black Indelible Ink

dward Opner		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Reg. No.
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 14, 2006 3. Time of Death 0255 hrs
		4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death 4d. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 18. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 18. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 18. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
апу		Usual Residence of Decedent 10a. State
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ith the Mary 23a or 28a notified at	Director	830 Cooks Lane 2/229 USA
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland b and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medreal Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 No Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc.
hours after 'natural", Examiuer	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
vithin 72 h ene er than "n Medical E	Completed	12 College (1-4 or 5+) Dietary Aide Veterans Hosp.
b, MD 21215-0036 and 2 should be filed within 72 teath and Mental Hygiene tem 27 is marked other than "traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last) William Opher 18. Mother's Name (First, Middle, Maiden Surname) Grace Cole Opher
MD 2 od 2 should flith and Mi m 27 is ma aumatic e	٥	19a. Informant's Name/Relationship (Typle, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nrs. Grace Opher 830 Cooks Lane Balto. Md. 21229
DOFE ages I nt of F t: If i		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify:
Baltin permit P. Departme Importan		21. Signature of Funeral Service Licenseer Rull Joseph L. Russ Funeral Home, P.A.
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart latture. List only one cause on each line. Immediate Cause (Final disease a Methadone and alcohol intoxication Approximate Interval Between Onset and Death Death
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To wit To Con	Med	29b. Signature and title of certifier 29c License number O.C.M.E. April 14, 2006
		30. Name and address of person who completed cause of death (Item 23a)
	tate	
Regis	trar	APR 1 8 2006 April 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month **Physician** 200 more /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Manor timo Ton If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign
 Country). Social Security Number 6. Sex 8. Date of Birth Funeral 213-20-1245
Usual Residence of Decedent Months Days Hours Min. 10 M 2□F Yrs ira Director with the Maryland 10d. Inside City Limits 10c City Town or Location 10a State 10b. Counts or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Marylana more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22 12. Was Decedent Ever in U.S. Armed Forces?

1 Ø Yes 2 □ No If Yes, Give Year or Dates: or Items 23a by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or Ite 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4or 5+) Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Importent: If them 27 1s marked any injury or other traumatic events. raimore almore (wile) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Balto, Md 10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date X Burial 2 Cremation 3 Removal from State 122/2006 * 4 ☐ Donation 5 ☐ Other (Specify) oua On ar 21. Sign sture of Funeral Service License 22. Name and Address of Facility Home P.A. m. Md. 21216 Funeral Home, tve. Balto, Md. Joseph L. Ru 2222 W. Nor The Ave. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical streture Pulmomory distol Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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State Registrar 30. Name and

31. Date filed file

32/Registrar's Signature

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			1 - For State Registrar	State of	Marylan		artmen					Reg. No.	06	12145
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1	/Medio		4a. Facility Name (If not institution Baltinese Rek	LIEN EX		are	4b. City.	111	Location of		7	4c. Cc	ounty of Death	0,2//
and a state	Funeral Director		5. Social Security Number 187-14-0921 Usual Residence of Decedent	6. Sex 7.	Age (In yrs. 83	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 2	5,192	9. Birthi Cou PA	place (State or Foreign ntry)
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by the course of	×	nding use a	υ/Μ¢	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	arv
by the course of	Ď.	death	icia	in the past 12 months? 1				
by the course of	0	et the	Phys	9 ☐ Unknown				
by the course of	ŝ	res th	Š	Part II. Other significant contained is contained to beam but not resulting in the un	derlying cause given in Part I.	11		_
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by the course of	<u>)</u>	endin sath. or: Af he fur	atic	2 Accident investigation				
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only (Ch	Ž	or Att	Ě	determined 289. Place of Injury - At nome, farm, stre	et, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	Route Number,
Check only one) 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due to the cause(s) and due		pitei ours a eral C		29a Cartifier Cartifying Physician To the heard and a land				
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hos 24 hc Fun etely	dica	2 modical examiner: On the pasts of examination and/or invi	estigation in my opinion death occur	red at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)
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State Registrar State Registrar		TX1		30. Name and address of person who completed cause of death (Item 23a) (Type, F	'rint)			
Registrar ADD 1 0 2006		0		31 Date field (Month Day Year)	11 57. SAUS	y mo		
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			State of Maryland / Dep	eartment of Health and Mertificate of Death	ental Hygi	•	12147
			Depedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medic		JACKIE Lee PETRY		FPRIL	14 2006	8:30 AM
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			2341 West Benson Road	WESTMINSTER		CARRI	
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday 2 14 33 1 AM 2 F 59 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birth Cor	place (State or Foreign intry) W V
Ī	pu ,		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or L	onation			10d. Inside City Limits
	shov	_		TMINSTER			1 Yes 2 No
	Ne M	Director	MO CARROLL WES	10f. Zip Code	100	g. Citizen of What Cou	
	with t	늅	2341 West Benson Road	21158	100	A < A	into y :
	eath	era	T		city Yes or No-	14. Race - Amer	ican Indian,
	r Iten	Funeral	1. Never Married 2 ☐ Married 1 ☐ Yes 2. No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
3	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ♣No Specify:		Specify: W	hite
	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir	16	6b. Kind of Business/I	ndustry
7	ithin 19.	nple	Flementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)		DISABLE	=0
V	be filed within 72 hours after death with the Maryland tat Hygiene. Indother than "natural", or Items 23e or 28e-f show event, the Medical Evaniral retails the natified at			18. Mother's Name	/First Middle Mr		
2	bed late	Be	17. Father's Name (First, Middle, Last)		HY CA		
Ž	hould d Mei mark mark	은	19a, Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rura.			n Code)
<u>8</u>	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic			•		Vinosoz me	
บ์	Heal Heal tam 2		20a. Method of Disposition 20b. Place of Disp			Oc. Location - City or 1	
2	© ° ± ≿		1 ☐ Burial 2	Amoil Crem. 14/15/	2006 L	WIN FICHO	mo
	permit. Page Department o Important: If any Injury or once.			22. Name and Address of Facility	v Zumbr	WW FIT A	nonco
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			23a. Furth. te the disease, o complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arres	st,	Approximate Interval Between Onset and Death
,00,	Physician /Medical Examiner physician and physician and physician and physician site physician are physician and physician are p	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	i'deni'a			
0	physics the	-	d				
O. BOX O	that the death certifica ed by the attending ph detached for use as th	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver Month	very Day Year
Z.	uires that signed b	by P	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did toba	icco use contribute to	the cause of death?
ğ	w require been sig should b		Protound mental Re	tardation	1 🗆 Yes	2 □ No 3 □ Pro	bably 4.20nknown
Records,	e fa has je 2	Completed	Hy pothy roidism		24a. Was an autopsy performe	prior to c death?	opsy findings available ompletion of cause of
VII	sician: Th certificate rector, pag	a	25. Was case referred to medical	26. Place of Death			20110
		To B	examiner? 1 Yes 2 No	ent 3 DOA Other: 4 Nursing Hon	ne 5 Residen	ce 6 Other (Spec	ify)
5	ding Phys		27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury Injury	of 28c. Injury at 2	28d. Describe how	v injury occurred	
VISION		Certification;	2 Accident investigation	M 1 Yes 2 No			
ž	il or Attendater deatl Diractor:	ıţį.	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specty)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ב	Hospital or 24 hours afte Funaral Dir tely filled in						
	To the Hospital or within 24 hours afte To the Funaral Dii completely filled in	Medical	29a. Certifier (Check only one) Check only one) 2☐ Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the within 2 To the complet	Me		29c. License number	290	d. Date signed (Month	, Day, Year)
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	.1		30. Name and address of person who completed cause of beath (Item 23a) (Type	e, Print)		1011	21784
	H		James L. Forsberg www	1350 Progress We	7#117	+ Eldersh	my med
	Sta		31. Date filed (Month, Day, Year) 22. Registra's Signature	de	/		V .
D	Regist		APR 1 8 2006	29c. License number 3356/ e, Print) 1350 Progress Wes			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** POPOV April 2006 LEONID 8:02 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ba Himore of Baltimore Hos Pita N/A Sinai If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 1**∑**M 2□ F Months Days 213-51-3598 68 UKRAINE Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 🕅 No BALTIMORE REISTERSTOWN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 USA 336 LAUREN HILL COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 💢 No WHITE þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MACHINE OPERATOR MACHINERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be POPOV **EMILIA** MERTVAYA IZRAIL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRINA GOLOVIN / DAUGHTER 336 LAUREN HILL COURT - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM 4 ☐ Donation 5 ☐ Other (Specify) 04/16/2006 REISTERSTOWN, MD 21. Signature of uneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. a 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disartse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo Cardial hours Due to (or as a consequence of): Heart Disease thero Scierotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Sigmoid Colectomy Hemicolectemy Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Colon Cancer, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical examiner?
1 X yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760, : After this certifice s funeral director, p death. filled in by the Director:

within 24 hours a

To the Funeral C

completely filled i

Funeral

Director

28a-f show

the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If tem 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Mark Gal Examination once.

Physician

/Medical

Maryland 21215-0036

Baltimore,

State Registrar

n

31. Date filed (Month, Day, Year)

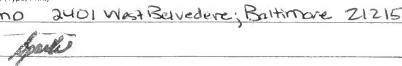
29b. Signature and title of certifier

29a. Certifier one)

Grenevier B. Melton-Meany, mo 32. Registrar's Signature

am southe Missioner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Kes000

29d. Date signed (Month, Day, Year)

April 14, 2006

8 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer **Physician** ANNA RING 9:50 PM <u>April</u> 17 2006 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner St. Joseph's Nursing Home Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 K Months Yrs 97 Director 215-40-2852 Marvland Usuel Residence of Decedent e filed within 72 hours efter death with the Maryland bi Hygiene.
other than "naturel", or flems 23s or 28s-f show vent, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Directo Maryland Anne Arundel Severn 10g. Citizen of What Country? 10e Street end Number 10f. Zin Code 7815 Faulkner Road 21144 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Š 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 end 2 should be file Depertment of Health end Mentel Hy Important: If Item 27 is marked other any Injury or other traumatic event Be Ralph E. Powell Anna Marie Fritzges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William P. Fea a/Son 7815 Faulkner Road Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 4/20/06 Baltimore, MD 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee 301 Frederick Road Catonsville, MD 21228 Edward A. Gregorchik

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician Immediate Cause (Final disease or condition resulting in death) /Medical EMBOLIC STROKE 21 DAYS Examiner Due to (or as a consequence of): Examine FIBRILLATION 16 MONTHS ATRIAL lew requires that the death certificate be executed ig physician end es the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings availeble prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tyes 2 100 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA P 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Naturel 2 Accident 5 Pending deeth. 1 Tyes 2 No investigation To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical (Check only 29b. Signature and title of celtifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 17, 2006 D0040012 m.D 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 405 FREDERICK ROAD, SUITE DOY, CATONSVILLE, MD 21228 OULTON 31. Dete filed (Month, Dey, Year) 32. Segistrar's Signature APR 1 8 2006 Registrar Look at Sun

DHMH 16 Rev 6/95

			1- State Amend Ite	State of Maryland / Department of Health and Mms 7,8, per FH,G854,04/28/06dbb.	lental Hygi	ene g. No. 0 0 6	12150
	Physici /Medi		1. Decedent's Name (First, Middle, Las Edward	Robertson	2. Date of Death Month April 1	Day Year	3. Time of Death 9:40am M
The second	Examir		4a. Facility Name (If not institution, give	street and number) 4b. City, Town, or Location of Death		4c. County of Deat	h
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	Funeral Director		5. Social Security Number 6. Sec. 218-05-1036	X M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	6/22/1914	hplace (State or Foreign untry) Aryland
	anyland show	-	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
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Object	ges 1 g t of He If Item or oth		20a. Method of Disposition 1	Removal from State cemetery, crematory or other place)	Date 20	Oc. Location - City or	
altimor	t. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify, 21. Sign tun, of Funeral Service Licens	Garrison Forest 7/19/	2006 6	wings	
Ba	permit. Departm Importa any inju		Joseph	Ly Suss Figure 2222 Whorth Ave	uneral to	tome, P.A	6
			snopk, or neart railure. List only o	lications that caused the death. Do not enter the mode of dving, such as cardiac	or respiratory arres	st,	Approximate Interval Between
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8760,	ate be	dicai	(d			
9	leath certific attending p	/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		23d. Date of deli	
Box	ie death the atter hed for i	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.0	that the ed by th detach	Phy	9 Unknown	ntributing to death but not resulting in the underlying cause given in Part I.	23a Did toba	cco use contribute to	the course of death?
Division of Vital Records, P.O.	sign d be	ed by	Dementia,	diabetes mellitus	1 ☐ Yes	_	bably 4 Unknown
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<u>~</u>	: The cate he	Con			performe	ed? death? No 1 ☐ Yes	
Vita	sician: Th certificate irector, pag) Be	25. Was case referred to medical examiner?	26. Place of Death dospital: 1 Miliopetical: 2 SR/Outpatient 2			
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DIV	tal or Att s after d el Direct ed in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
0	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ledical (29a. Certifier 12 Certifying Phy (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place, a ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau ed at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month	, Day, Year)
	1		1 /1. And,	long they; us D25205	H	pril15,	2006
	2		30. Name and address of person who of	completed cause of death (Item 23a) (Type, Print) C BM 6701 N. Charles St.	Balte	md Zo	2050
	Sta		31. Date filed (Mornin Pray, Year) 20	06 3 Registrar's Signafure			,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death RUCKS 3, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Peath BALTI WORE REHABILI TATION EXTENDED CARE If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 9. Birthplace (State or Foreign Months Days 432-09-3181 Usual Residence of Decedent 1 XM 2□ F Hours 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 □ No Itimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Black Decedent's Usual Occupation (Give kind of work done during most of working life. "DO NOT use retired") 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) echnici 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack (wife) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 5 10. Md. 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 2006 4 □ Donation 5 □ Other (Specify) Son 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

JOSEPH TRUSS F Joseph Home P.A. 2222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown litions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

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Completed

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Examiner

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Funeral

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Show

oriant: if item 27 is marked other than "natural", or items 23s or 28s-1 shov Injury or other traumatic svent, the Madical Examblar must be notified at

I Hygiene.

Department of Heelth and Mental Honortant: If them 27 is more any fulury or other and the second

with the Maryland

Baltimore, Maryland 21215-0036

led by the attending physician and detached for use as the burial-transit page 2 should be

Be Complet

2

Certification:

Medical

The law requires that the death certificate be executed

To the Hospitel or Attending

rector;

within 24 hours a To the Funeral C

Division of Vital Records, P.O. Box 68760

Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown
ed by Pr	Part II. Other significant cond

25. Was case referred to medical examiner?

1 ☐ Yes 2 No

27. Magner of Death

1 Natural

2 Accident

3 🗌 Suicide

4 Homicide

ARTERY RENAL CHRONIC

200.	Did tobacc	0 436 60	illibute to the cat	use of death		
	1 🗌 Yes	2 🗆 No	3 Probably	4 Unkno		
	Was an autopsy performed?	24b	Were autopsy fir prior to completi death?	ndings availa on of cause		

2 No

1 Yes

24b. Were a prior to death?		ngs available of cause of
	2 □ No	

Number or Rural Route Number

26. Place of Death (Check only one) Hospital: 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

5 Pending investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No		
6 Could not be determined	28e. Place of Injury - At ho	me, farm, stre	et, facto	ry, office		28f. Location (Street and City or Town, State)	

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	use

29b. Signatere and title of certified

OBSTRUCT

address of person who completed cause of death (Item 23a) (Type, Print) 0. Name and addr AURORA LOCH

PAVEN BOULEVARD, BALTIMORE, 3900 32. Registar's Signature

06

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:55а м 14, Edward H. Reiman April 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1 XM 2 F Yrs. 213-34-3398 69 July29,1936 MAryland Director Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10d Inside City Limits 10h County tha State 28a-f show out by notified at 1 ☐ Yes 2 No MD Baltimore Baltimore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8018 Gough Street 21224 USA Негле 23а Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian. 1 Never Married 2 Married PeiMAN ö 1 ☐ Yes Ž No Specify: White Specify: 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT_use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pen Galvinized al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fit and Mental H John Reiman Freida Brige ss 1 and 2 should be of Health and Mental litem 27 le marked 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Surrick /daughter 1302 Gibson Road Bensalem PA20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Depertment of HImportant: If Iter
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4/15/06 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 300 Mace Ave.Balto. MD 22. Name and Address of Facility Connelly Funeral Home of Essex 21221 onn 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastahe Venal cell carcinoma 9/05~6MGS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Examiner anding physician and use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. P Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No arky disease 1 Yes 2 No SCIZURES WISTOM 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this After this funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours efter death uneral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Director filled in be 4 T Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Descripting rinyscian: 10 the basis of ray knowledge, death occurred at the little, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the within 2 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sutow

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death dent's Name (First, Middle, Last) Year Month **Physician** Kittenhouse 2:00 A Pril 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Baltimore torest Haven
5. Social Security Number 6. Home Nursing If Under 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min 1 □ M 2 2 F Yrs. HOUSTRANIA 302-07-7278 Director 24 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND BALLimore WINWO 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A 3003 7 TILLE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 250 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: STIHW 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CALLIMORE LOUNTY I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOOL NURS 471A3H 70 7930 18703 other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) irmit. Pages 1 and 2 should be file apartment of Health and Mental Hyportent: if item 27 is marked oth y injury or other traumatic event PFLUVFILOZI EOGAR KTic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2617250,00 CIARHARD 3003 HUMING (2002 ORINE DOROTHY 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or otl APRIL 18 Burial 2 Cremation 3 Removal from State JORELAND MEM. HARK LECKNITTS TARYLAND □ Donation 5 □ Other (Specify) 21. sign that of Fun ral Service Lick see 22. Name and Address of Facility = NEMARIES 21234 ELUNG HUNGER SOUND lary Lano Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SIPSIS Physician /Medical Due to (or as a consequence of) **Examiner** NEUMONI Sequentially list conditions, if any, leading to immediate saude. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of) the attending physician hed for use as the burial P.O. Box 68760 pe Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day signed by the atte in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions Antributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No EIMER 24a. Was an autopsy performed 1 ☐ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DQA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after c 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)28591 gneem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print AKHANI, 7220 HEIGHTS 1 ASNEEM

State Registrar 31. Date filed (Month, Day, Year).

APR 1 8 2006

DHMH 17 Rev 1/2001

ORIGINAL

32. Registrar's Signature

			_ For	State of Maryl	and / Depa	artment of H	lealth and I	•	•	12151
			1 - State Registrar		Cei	rtificate of	Death	1	No.UUU	16.109
	Physici /Medic	_	Decedent's Name (First, Middle, La Esther	S.	Roseliu	ıs		2. Date of Death Month April 15	, ^{Day} 2006 Year	3. Time of Death 7:20 P M
	Examin	200	4a. Facility Name (If not institution, give 2906 Dunran Road			4b. City, Town, o	r Location of Death ${f k}$	1	4c. County of Death Baltimore	
34	Funeral Director		Social Security Number 6. 8		yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) November 4	9. Birth Cou ,1924 Mary	place (State or Foreign ntry) rland
3	yiand how		Usual Residence of Decedent 10a. State 10b. County	100	:. City, Town or Lo	ocation				10d. Inside City Limits
	28e-1 e	rector	MD. Baltim	ore	Dunda	10f. Zip Code		100	g. Citizen of What Cou	1 ☐ Yes ZXNo intry?
3	3a or	0	2906 Dunran Road	l Apt B		21222	2		USA	
99	permit. Pages 1 and 2 should be liled within 72 hours arier death with the maryland Department of Health and Mental Hygiene. Department: If them 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Modical Examinar must be nutified at <u>once.</u>	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race · Ameri Black, White Specify: Wh	
70-613	in "natura in "natura Medical E	Completed	15. Decedent's E (Specify only highest gr	Education rade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	6b. Kind of Business/Ir	W S
7 7	or tha	Com	12 years	College (1-401 5+)	Cal	ble Splic			estern Ele	ctric
ylarid	Mental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, Last William Levi Sel					ne (First, Middle, Ma rtrude Wh		
Mary	lith and h		19a. Informant's Name/Relationship Margaret L. Lupt					ral Route Number, rundalk , Ma	City or Town, State, Zi ryland 21	ip Code) 222
nore,	ages 1 ar ant of Hea at: If item y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	☐Removal from State		osition (Name of matory or other pla Crematory		 	oc. Location - City or T altimore C	
Baltimor	permit. P Departme Importan eny injur pnce.		21. Signature of Funeral Service Lice		22	Name and Addre	Funeral	Home Of D	undalk,P.A undalk, Md	21222
٧			23a. Part1 En er the disease, or con shock, o heart failure. List only	nplications that cau will the yone cause on each line.						Approximate Interval Between Onset and Death
	Inysician /Medical		Immedia e Cause (Final disease or condition resulting in death)	Due to (or as a cor	TEL SUL risequence of):	MS_				3 months
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٥.	be executed sician and burial-transit	ai Examlner								
20	certificate nding phys use as the	edic		u.						
<u>n</u>	death e atter id for u	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 n/onths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of deliv	very Day Year
as, r.	requires that the een signed by th hould be detache	þ	Part II. Other significant conditions	contributing to death but no	t resulting in the u	ınderlying cause gı	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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	• Hospit 24 hour • Funera letely fills	edical (29a. Certifier Centifying P (Check only one) Centifying P	Physician: To the best of my aminer: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	th occurred at the to	me, date and place opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title digertifier	MI		29c. Licen	se number	7	d. Date signed (Month	*
	1		30. Name and address of person who	o completed cause of death	(Item 23a) (Type,	, Print)	10 (01		M) [] [06	
	()	ate	MYO (I'M N(31. Date filed (Month, Day, Year)	GIIH P		ECPTIF	RO	BACTO	MJ 21	23/
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DHMH 17 Rev 1/2001

		-	1 - For State of Maryland	-	artment of H			ene g.N.O 6	2155
	Diam'r.		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Jane Hewitt Reid				April 14	4, 2006	11:00A M
	Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Death	
			Wilson Health Care		Gaither			Montgomer	·
	Funeral		5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Cour	
	Director		220-05-0946 ILM ZWF 86 Usual Residence of Decedent	110.			June 21	, 1919 Virg	unia
	fand ow		10a. State 10b. County 10c. City,	fown or Lo	ocation			1	0d. Inside City Limits
	Mary -f sh	ţō	Maryland Montgomery Rocl	cvill	e				1 XYes 2 No
	r 28e	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cour	ntry?
	h with	ai D	5923 LeMay Road		20851			United Stat	es
	deet deet	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race - Americ Black, White,	
9	or Ite	Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 2 ဩ No		,	Specify:	
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12	within lene. then "	m d	Elementary/Secondary (0-12) College (1-4or 5+)		retary	-,		County Gove	0
	Hygie Hygie ther ant, II	e Co	17. Father's Name (First, Middle, Last)	bec	.ictary	18. Mother's Name			Timent
an	ould be Mental arked o	00	Charles Marks			Ida Hew	ritt		
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Ma	and 2 seeth ar n 27 is		Edward W. Reid/Son	5923	LeMay Ro	ad, Rockv	ille. Ma	rvland 20	851
ē,	ges 1 and 1 t of Heelth If Item 27 or other tr	1 9	20h Plac	e of Disno	osition (Name of matory or other place			Oc. Location - City or To	own, State
JU O	0 0		1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from State Mont '4 ☐ Donation 5 ☐ Other (Specify)	gome	ry ium. Inc.	200		ockville, M	[arvland
Baltimore,			21. Signature Funeral Service Doensee	20	2 Name and Addre	ee of Facility Poh	ort A D	umphres Fu	neral Home/
B	permit. Departr Importe any Inju		MOORO MOORO	ontgomery A 2805	venue				
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	ter the mode of dyin	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between
-	Pnysician	e n	Immediate Cause (Final	Kil	Thren	o lad	celt)	Onset and Death
10	/Medical		disease or condition resulting in death) a. Due to (or as a conseque	nce of):	/			ecc'dent	
	Examiner		Sequentially list conditions & Recent	ces	eleser	vaseu	lar a	ceident	
7	D :=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):					
V	be executed siclan and burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence)	ana af):					
50,	ate be ex nysiclan a he burial		Due to (or as a conseque	ice oi).					
8760	<u>w</u> > w	Physician/Medical	d						
9 ×	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnance	v				23d. Date of delive	erv
Box	leath certifical attending phy I for use as th	clan	23b. Was decedent pregnant in the past 12 months? 1 \(\rightarrow \text{seq} \) 28 \(\text{Veb birth } 2 \) Fetal d 4 \(\rightarrow \text{pregnant at time of dea} \)	eath 3[□Ectopic pregnancy □ Other (specify) _	y		Month	Day Year
o.	the d y the tched	ysi	9 ☐ Unknown						
₽.	es that the death cer igned by the attendin be detached for use	y PI	Part II. Other significant conditions contributing to death but not result	ng in the u	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
Records,	quire n sig uld bi	Completed by	Carracy artery tescale.	42	chemi	e .	1 🗌 Ye	s 2. Prol	oably 4 Unknown
00	aw requir ts been si 2 should	olet	Cardiamyopathy. 4x2	ial	febrile	Cotion	24a. Was an	24b. Were auto	opsy findings available impletion of cause of
	iclen: The lav certificete has rector, page 2	lmo	House to sail al dec	celle	tres Chen	ni i 11 M O MA	autopsy perform	ned? death? ☑ No 1 ☐ Yes	
Vital	en: tifice tor, p	Bec	25. Was case referred to medical			26. Place of Death			
>	Physicien: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Ef	VOutpatie	nt 3 DOA	ner: 4 Nursing Hon	ne 5 🗌 Resider	nce 6 Other (Specia	(y)
Jo L	g Ph ter th neral	<u></u>		8b. Time o	of 28c. Injur	ry at 2	8d. Describe ho	w injury occurred	
io	Attanding ir death, actor: After by the fune	atio	2 Accident investigation			Yes 2 No			
Division	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st	reet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or Rur , State)	al Route Number,
0	Ital o irs aff rel DI	Cel							
	To the Hospital or Attanding Physicien: The twithin 24 hours after death. To the Funerel Diractor: After this certificete ha completely filled in by the funeral director, page	edical	29a. Certifier 1 ☐ Certifying Physician: To the best of my knowl (Check only one) 2 ☐ Medical Examiner: On the basis of examination and manner stated	edge, deat n and/or in	th occurred at the tire execution, in my c	me, date and place, a opinion, death occurre	ind due to the ca ed at the time, da	use(s) and manner as s ite and place, and due t	tated. o the cause(s)
	thin 2 tha mplet	Med	one) and manner stated. 29b. Signature and title of certifier	,	29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
	F 3 F 8		1/4.D.1. +2 11	1.					
	(Tr	1	30. Name and address of person who completed cause of death (Item 2	Type	Print)	1000000		,	
	P		1V-ROBERT BIRS (HBALL	1)4	11) GA	-171+2R	SECTA	quil 14,	847
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	re	P . M .				
	Regist	rar	APR 1 8 2006 Resume A	The state of the s	DEALE!				

			1 - State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L			giene 006	12156
	Physici /Medio		Decedent's Name (First, Middle, Las FREDE		LTER RING	GGER, JR	•	2. Date of Dea Month April	14 Day 200	3. Time of Death 8:10 P M
	Examir		4a. Facility Name (If not institution, give Greater Baltimore		Center	4b. City, Town, or Towson	Location of Deat	h	4c. County of D Baltimon	
	Funeral Director		213 14 3347		e (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 07-09-	1922 9.	Birthplace (State or Foreign Country) MARYLAND
	Maryland a-f show	tor	Usual Residence of Decedent 10a. State MD. BALTIN	IORE	10c. City, Town or Lo	ocation TIMON	NIUM			10d. Inside City Limits 1 ☐ Yes XX No
	h with the	al Dire	10e. Street and Number 114 GALEWOOD R	OAR		10f. Zip Code	1093		10g. Citizen of What	,
મું કુટ	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show he Medical Examiner result be notified at	by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? VXYes 2 N If Yes, Give Year or Dates:	lo.	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes XX No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		merican Indian, thite, etc. WHITE
21215	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Heatth and Mental Hygiene. Importents if Item 27 is marked other than "natural", or iteme 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be notified at 2008.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0·12)	cation de completed) College (1-4or 5 2 YEARS	(Give	dent's Usual Occupa kind of work done d DO NOT use retired) [VIL ENG]	luring most of wor	rking	16b. Kind of Busine	
Maryland 3	should be filed and Mental Hygin i marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) FREDERICK	WALTER F	RINGGER, S	SR.	18. Mother's Nar MARY	ne (First, Middle, ELIZABE	<i>Maiden Sumame)</i> ETH GURSk	(1
	1 end 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (7 ALICE M. RINGGER			*			RYLAND, 2	
Baltimore,	Pages 1 ement of Hemant: If item ant: If item ury or other		20a. Method of Disposition XX Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			esition (Name of matory or other place ALLEY M.G		Date 19-2006	TIMONIUM,	
Balt	permit. Pag Depertment Important: i any injury o once.		21. Signature of Funeral Service Licens	(R.G.R		2. Name and Addres		- HOME,IN	1050 Y VC. TOWSON	ORK ROAD 1,MD.21204
68760, <	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cut)	10.	relig) s			631,	Approximate Interval Between Onset and Death I mmediate
.O. Box 68	death certiff e ettending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
٥	es De de	þ	Part II. Other significant conditions co	intributing to death be	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did to		e to the cause of death? Probably 4 Unknown
al Records,		Completed	01-01(E					24a. Was a autop perfor 1 Yes	sy prior death	autopsy findings available to completion of cause of ? es 2 \[\sum \text{No} \]
f Vital	Physician: Th this certificate rat director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 LER/Outpatien	nt 3□ DOA Othe	r	ith (Check only or Iome 5 ☐ Resid	ne) ence 6 □Other (S	ipecify)
ion of	ding After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		Work			ow injury occurred	
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manaer sta	of my knowledge, death examination and/or in- ited.	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	, and due to the c rred at the time, d	ause(s) and manner date and place, and	as stated. due to the cause(s)
		Me	29b. Signature and title of certifier	7	Mal	29c. License	number 6 8 8	2	29d. Date signed (M)	onth, Day, Year)
	Sta Registr		30. Name and address of person who or Carls. Frodman 31. Date filed (Month, Day, Year) APR 1 8 2006	ompleted cause of de	eath (Item 23a) (Type,			crsver, 6	Md. Z	286

			1 - For State Registrar	State of M	larylan			nt of He te of D		nd Me	-	gieņe Rog. No.	006	121	57
	Physici		1. Decedent's Name (First, Middle, Last)			RE	FAV	ES		Date of De Month		Year 2006	3. Time of 9:05	
	/Medio Examir Funeral		4a. Facility Name (If not institution, give THE JOHN'S HOPKIN 5. Social Security Number 6. Se	Is HOSPI	TAL	last birthday)	Bal	HMOTO r 1 Year	If Under 24	Death	Date of Bir	4c.	N/A 9. Birth	place (State	or Foreign
	Director		Usual Residence of Decedent]м 2∭ г	7		Months	Days	Hours	Min. 5	(Month, Da	935	NOR	TH CAF	ROLINA
	he Marylar 28a-f show outlied st	Director	MD N/A			y, Town or Lo	ORE				1				City Limits 2 No
	eath with the 23a or 27 must be n	Funeral Dir	10e. Street and Number 1543 APPLETON ST 11. Marital Status	• 12. Was Deceden	t Ever in U	S 13 V	2	21217	spanic Origin	n? (Speci	ify Yes or No	τ	en of What Cou SA 4. Race - Ameri		
036	ours after d ai', or itan Exeminer	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2√2 If Yes, Give Year or Dates	? X No		f Yes, spe	cify Cubar	Specify:	Puerto Ri	can, etc.)		Black, While,	etc.	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural; or itams 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) -12-	cation le completed) College (1-4or -0-	5+)	life. L	kind of wi DO NOT L	ral Occupa ork done di ise retired)	uring most a	of working	7		d of Business/Ir	•	
/land	should be filed and Mental Hygis marked other umatic event, It	To Be (17. Father's Name (First, Middle, Last) RICHARD CROMARTI	E							First, Middle ROMART		Sumame)		
, Mar	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (7) JACQUELINE BEVER			EP-DAU	GHTEF	2) (Town, State, Zij LTIMORE		21224
altimore,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other 2006.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		GAR		natory or FORES	other place ST VE	rerans		9-200	6 OWI	ation - City or T	LS, MI	
Ball	permit Depart import eny inj		21. Signal Funeral Service Licens) Hu.	3re		721-2	7 N.	MONRO	DE ST	BAL	IMOR	AL HOME E, MARY		
	Physician /Medical		23a. Part1/Enter the disease, or compl shock/or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each	line. UNG	CAN			, such as ca	ardiac or i	respiratory a	rrest,		Approxima Interval Be Onset and	tween Death
8760,	The law requires that the death certificate be executed x is the law requires that the death certificate be executed by the attending physician and page 2 should be detached for use as the burial-transit and the certification is the certification of the certical of the certification of the certification of the certificatio	dical Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:	e a conseq	uonea sil):									
P.O. Box 6	at the death certific by the attending p tached for use as	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗆 Feta	Idéath 3□	Ectopic p					2	3d. Date of deliv Month	-	Year
	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death	bul nol res	ulting in the ur	nderlying	ause give	n in Part I.			obacco us	e contribute to t		death? Unknown
al Records,		Completed									24a. Was autop perfo 1 Yes		24b. Were auto prior to co death? 1 \(\text{Yes}	mpletion of a	available cause of
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	fospital: الما				Othe			Check only o				
Division of	ng Phy (fter this Ineral d	tlon: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 28a. Date of Inj (Month, D	ury	28b. Time of Injury		28c. Injury Work	4 🔲 Nursi	28	5 ☐ Resid d. Describe f		Other (Special occurred	(y)	
Divisi	ai or Atter s after dea ii Director od in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - Al ho etc. <i>(Specif</i>)	ome, farm, stre	eet, factor	y, office		28	f. Location (S City or Tox	Street and vn, State)	Number or Rura	al Route Nun	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis and manner s	of examina	wiedge, death tion and/or inv	estigation	at the fina n, in my opi	Jate and linion, death	place an occurred	d due to the at the time,	rausa(s) date and	and mormer as s place, and due to	the cause(s	s)
	To t With To t	Σ	29b. Signature and title of certifier	M.D.			1	c. License	number	00			signed (Month,		,
	7		30. Name and address of person who co	THE JOHNS	HOPK	INS HO	Print)								
88	Sta Registr		31. Date filed (Month, Day, Year)	32. 199 9isi	trar's Signa	ture	and a	PE)				,		•	

			For State	State of Ma	ryland /			Health and M	lental Hygi	ene	0.6	12158
_			Registrar 1. Decedent's Name (First, Middle, La	2/1		Cer	tificate of	Death	2. Date of Deat	g. No.	-10"	3. Time of Death
	Physicia		LEONAR			ROT	rkovitz		APRIL	Day	Year 2006	9:25 A M
	/Medic Examin		4a. Facility Name (If not institution, giv			- KO		or Location of Death	711 112		y of Death	J.20 //
			6414 PARK HEIGH					BALTIN				N/A
	Funeral Director		5. Social Security Number 6. S 217-14-5285	ex 7.Age XIM 2□F	(In yrs. last 85	birthday) Yrs.	Months Days		B. Date of Birth Day, JAN. 29,	1921	9. Birthp Coun	place (State or Foreign htry) MD
	D D		Usual Residence of Decedent						, , , ,			
	arytai show	č	MD 10b. County	۸	10c. City, To		TIMORE				1	0d. Inside City Limits 1 1 Yes 2 No
	28a-f	Director	10e. Street and Number	٦	-	DAL	10f. Zip Code		10	g. Citizen of	What Coun	
	death with the Maryland me 23a or 28a-f show ritheat be notified at		6414 PARK HEIGH	TS AVENUE	#C-2			21215				USA
	tame	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decedent of Yes, specify Cut	Hispanic Origin? (Spo dan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
50	hours after turel', or its	by F	1 ☐ Never Married 2 ☐ Married 3 💢 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	lo	1	☐Yes 2 No	Specify:		Speci	fy:	WHITE
2-0036	2 2 3	eted	15. Decedent's E (Specify only highest gra		16	6a. Deced	ent's Usual Occu	pation during most of work	ina	16b. Kind of E	Business/Ind	dustry
2	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	SALI		during most of work ad)		ΓΔΡΙ ΔΝ	BR∩TI	HERS GLASS
7	Hyg Hyg it,	Be Co	17. Father's Name (First, Middle, Last			JALI		18. Mother's Name				TERS GENSS
yland	uld be Aental irked o	To B	ISAAC			ROTI	KOVITZ_	SARAH			LI	TVINSKY
Mary	2 sho and h is ma		19a. Informant's Name/Relationship (** *				tand Number or Run		•		Code)
ď	s 1 and f Health item 27 other ti		ROYCE MINKOVE / 20a. Method of Disposition	DAUGHTER	20b. Place	of Dispos	sition (Name of			20c. Location		own, State
Ē			1 🛱 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				natory`or other pla JNG MEN	CEM. 04/16	5/2006	W00	DLAWN	, MD
Baltimor	permit. Page Department of Importent: if eny injury or once.		21. Signature of Funeral Service Lice	isee		22.	. Name and Addr	ess of Facility S(OL LEVIN			
_	7 □ = 0		23a Part 1 Enter the disease or com	plications that caused	the death D			STERSTOWN			ILLE,	MD 21208 Approximate
	Physician		23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each lin			CANCER	g, 55625				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as			DANCER	<u> </u>				246an
	Examiner	_	Sequentially list conditions,	b. — Due to (or as								
/لا	uted t Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	000 to (51 de	я сопесущих	og-org.						
7	exect en and rial-tra		that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):						-
58/60,	icate be executed physicien and s the burial-transit	edicai		d							_	
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	ate of delive	arv
. Box	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 █ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnant Other (specify)_	су			onth	Day Year
ت ت	d by the de		9 ☐ Unknown Part II. Other significant conditions		it not resulting	a in the un	idarhijaa causa a	ven in Part I	23e Did toh	acco use cor	atribute to th	ne cause of death?
ds,	The law requires that the tite has been signed by the bage 2 should be detache	d b	Pattil. Other significant conditions	-	at their resulting	g in the or	derlying cause gi	YOU IN FAIL I.	1 ☐ Ye	_/	3 ☐ Prob	
Vital Records,	aw require s been si 2 should l	Completed							24a. Was ar		Were auto	psy findings available
Ĭ		Com							autopsy perform	red?	death?	mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death				
	Phys r this aral dir	7. 70	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of Injur	y 288	Outpatient b. Time of	t 3□ DOA 28c. Inju	4 Nursing Ho	me 5 X Reside 28d. Describe ho			v)
<u>o</u>	nding Ph ath. r: After th e funeral	ation	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury		ork?]Yes 2∐No				
Division of	To the Hoepitel or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could not be determined	e 28e. Place of Injubuilding, etc		, farm, stre	eet, factory, office		28f. Location (Str City or Town		ber or Rura	I Route Number,
	To the Hospitel or At within 24 hours etter d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Pl	ysician: To the best of	of my knowled	dge, death	occurred at the t	ime, date and place,	and due to the ca	use(s) and m	anner as st	tated.
	he Ho in 24 h he Fu pletely	edicai	(Check only 2 Medical Exa	niner: On the basis of and manner sta	examination	and/or inv	estigation, in my	opinion, death occuri	ed at the time, da	ite and place	, and due to	the cause(s)
\	To T Fo I	Σ	29b. Signature and title of certifier	080			29c. Licen	se number	29	d. Date sign	ed (Month,	Day, Year)
,	. 0		30. Name and address of person who	completed cause of d	eath (Item 23	a) (Ivne	Print)	00m)		114	2.0	2
_	10		-TISWIM	Kydito	++ 1	1831	8 WH	evetveel	KI Ba	ITUN	10.91	1206
	Sta Registr		31. Date filed (Month, Day, Year)	32. Régis tra	ar's Signature	Be	anti)	·				
			71 IV 1 0 1	LUUU MARKA	Charles And Annual Control	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 🕤 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 ear **Physician** APRIL 14 Pay 4:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SINAI HOSPITAL BALTIMORE N/A Months Days Hours Min. J. Movyh, Day, Year) 927 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2∏F 78 MD 220-20-5138 Yrs. Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene.
ther then "naturat", or items 23s or 28s-1 show 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits itsm 27 is marked other than "natural", or items 23a or 28a-1 shot other traumatic svent, the Modical Examinar must be notified at 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6414 PARK HEIGHTS AVENUE #C-2 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Completed by Specify 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ss 1 and 2 should be fill of Heelth and Mental Hy I tem 27 to marked oth Be **BLOOM** BROWNSTEIN PHILIP ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROYCE MINKOVE / DAUGHTER 3743 ASHLEY WAY - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of the Important: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 15 ☐ Other (Specify) 04/16/2006 HEBREW YOUNG MEN CEM | WOODLAWN, MD /5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final LUNG Proysician auri disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires thet the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 99 cate hes been sig 12 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate hes 1☐ Yes 200 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ٩ 1 ☐ Yes 25 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 2 ∏No investigation 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year)

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7

State Registrar

30. Name and address of person

eath (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hy

(3)	m	73	100	1	(1)	9	1	0
6	U	U	6	1	2		O	U

Physic		1- For State Registrar 1. Decedent's Name (First, Midd	late of Maryland	Certificat			and iv		2. Date of De		201		Time of Death
ledical Exan		Charles Edwa	-						Month April 11,		Year		1147 hrs
		4a. Facility Name (if not institution Bon Secours Hospita		r)	4	b. City, Town Baltimor		tion of Death		4c	. County of D		
Funera		Social Security Number		ge (In yrs. last birthda	ay)	If Under 1			8. Date of I	Birth (MM/		Birthp	lace (State or Foreig
Directo	r	218-58-3516	1XM 2F	53	Yrs.	Months	Days F	lours Min.	May	15,	1952	Man	ryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Locatio	n						10	od Inside City Limits
*	i	Maryland N	I/A		Bal	timor	2					1	X Yes 2 No
Maryla 28a-f:	Director	10e. Street and Number	,			10f. Zip Cod				10g. Citiz	zen of What	Country	?
ith the Maryland 23a or 28a-f show	<u> </u>	1262 Glyndon A					223				USA		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ten of Health and Mental Hygiene int. If item 27 is marked other than "natural", or items 23a or 28a-1 she in the Marian Prominer with the marked of the contract.	1 0	11. Marital Status 1 Never Married 2 N	12. Was Decede Armed Force	s?				o Origin? (Spikican, Puerto		No-	14. Race - A White, e		n Indian, Black,
after d	by Ft	3 Widowed 4 Div	1 X Yes vorced If Yes, Give Year or Dates:	²	1	Yes 2 X	No spe	ecify:			Specify: W	hite	2
2 hours af "natural	p pa	15. Decedent's Education (Spe	ecify only highest grade o	during				Give kind of w	ork done	16b. F	Kind of Busin	ess/Indu	ustry
5-0036 led within 72 hours after Hygiene other than "natural",	Completed	Elementary/Secondary (0-12)	College (1-4 c	m(m(orking life. E chanic	00 N OT u	se retired)			Sheet	Meta	al
5-00 led wit Hygien other	Son	17. Father's Name (First, Middle	ı, Last)		LICC	nanic	18 M	other's Name	(First, Middle				41
21215-0036 Juld be filed within 7 Mental Hygiene marked other than	Be	Robert G. Spa		10h 8	Moilina	Addross (S		Dorothy Number or R			ity or Town	State 7	in Codo)
MD 2 nd 2 shoul tlth and N m 27 is m	To	19a. Informant's Name/Relations Robert G. Spar			U	•		e Pasa					
re, MI 1 and 2 s Health a fitem 27		20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of E	Disposi	tion (Name o			Date		Location - Cr		
	0r 0411er	4 Donation 5 Other S		Metro (Cren	natory	Inc	. 04/2	14/06	Ва	altimo	re,	Maryland
Baltimo permit Pag Department Important:		21. Signature of Funeral Service	1	2	22. N	ame and Add	on Sc	ociety	Of Ma	rylaı	nd Inc		1 04000
Physicia	n	Thomas Gregor (23a. Part I. Enter the disease, o	r complications that cause	ed the death. Do not e	enter th	99 Fred e mode of dy	derio	CK Road as cardiac or	d Balt r respiratory a	imore arrest, sho	e, Mar ock, or heart	yIaı	nd 21228 Approximate Interva
/Medica	al	failure. List only one cause Immediate Cause (Final disease	e on each line.										Between Onset and Death
7,0		or condition resulting in death)	Due to (or as a conb.	nsequence of):									
	Je L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):									
1	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	nsequence of):									
outed and	CQ.		d.										
'60, cate be executed	ne burnal - tr Medical	UNPENDED	AMENDED										
9 at 6	ଳ ≥			come of pregnancy 2	Fet	al death	3E	ctopic pregna	incy	230	d. Date of de Month	livery Day	Year
Division of Vital Records, P.O. Box 687 Hospital or Attending Physician: The law requires that the death certific 24 hours after death Funeral Director: After this certificate has been signed by the attending it	ched for use as t Physician/	1 Yes 2 No 9 Ur	4 Pregnant nknown 9 Unknown	at time of death 5	Oth	ner (Specify)							
D. B t the de by the	ached P				n the u	nderlying ca	use given	in Part I.	23e. Dio	d tobacco	use contribu	te to the	cause of death?
, P.O.	e 2								1`	Yes 2 ⊌	/ No 3	Probab	oly 4 Unknown
ords w requi	; page 2 should be Completed									topsy	prio	r to com	sy findings available apletion of cause of
Rec The la	page 2								1 ✓ Ye	rformed? s 2 N	dea lo 1	th? Yes	2 No
ician: s certifi	rector, Be (25. Was case referred to medic examiner?	Hagnital:	atient 2 V ER/Out	estiont			eath (Check		Booide	ence 6	Other.	
Division of Vital Records, tal or Attending Physician: The law requir rs after death	completely filled in by the funeral director, page 2 should ledical Certification: To Be Complete		28a. Date of I	niury 28b. Tir			Injury at	Work?	28d. Describ	e how inj		Other.	
ion (tending eath or: At	the fur	1 Natural 5 Per 2 Accident Inve	Apr 11, 200 estigation	y Year) 06 1030 h	nrs	1	Yes	2 🗸 No	Subject si	tabbed			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	filled in by the fune Certification:	3 Suicide 6 Co	uld not be 28e. Place of	Injury - At home, fam	n, stree	et, factory, off	ice buildi		or Town	, State)	_		Route Number, City
Ospital ospital hours	ly fille		rermined (Specify) r Physician: To the best of		n occur	red at the tim	ne date a				/enue, Ba		
To the H within 24 To the F	complete	(Check only one) 2 Medical Ex	aminer: On the basis of e	xamination and/or inv									
To To	S 2	29b. Signature and title of certif	and manner state	. 1		29c. Li	cense nu	mber		29d.	Date signed	(Month	, Day, Year)
		totallu	mir-te	lleh .	>	C	.C.M.E			Apr	ril 12, 200	6	
10		30. Name and address of person Patricia Aronica-Pollo		of death (Item 23a) Medical Examir	ner	111 Pen	n Stree	t, Baltimor	e. MD 213	201			
10	State		r) 32. Fegis	trar's Signature	-			.,	-, 17				
Das	istra	APR 1	8 2006	ere H.	Carl	Wall &							

DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

		1 - For State Registrar	State of Maryland /		ent of Health and ate of Death	Mental H	ygiene Reg. No.	006	12161
Physic	eian	1. Decedent's Name (First, Middle, Las				2. Date of I Month April	Day	Year	3. Time of Death
/Med	lical	Milton Boyd Stur		45.0	ty, Town, or Location of Dea		15	2006 County of Death	2:20 A. M
Exam	iner	4a. Facility Name (If not institution, give 627 Walker Avenu			lewyde	atti		1timore	County
Funera	1	5. Social Security Number 6. S	ex. 7. Age (In yrs. last		der 1 Year If Under 24 Hr				place (State or Foreign ntry)
Directo		212 40 7230	ĎM 2□F 59	Yrs.	is Days Hours Will	Nov.	21,19		yland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
Maryli f sho	jo	Maryland Baltimo	ore County Idlev	wyde					1 ☐ Yes ŽŽNo
n the	Director	10e. Street and Number			Zip Code			zen of What Cou	•
ith wit. 23a o	ai D	627 Walker Aver	iue		1212			ed State	
INTYINIO CILISTONSO 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 1s marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Madical Examinar must be matified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1	If Yes, s	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2	(Specify Yes or I erto Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	, etc.
2 hou	ted	15. Decedent's Ec (Specify only highest gra		6a. Decedent's U	sual Occupation work done during most of w	varkina	16b. Ki	nd of Business/Ir	idustry
ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Tuse retired)		D	isabled	
iled w lygier ther ti	S	17. Father's Name (First, Middle, Last)	N/A	Unem	ployed 18. Mother's N	ame (First, Midd			
d be fill ental Hi	To Be	Harry G. Sturgis			Helene			,	
should nd Mer marke	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	ess (Street and Number or I	Rural Route Nun	nber, City o	r Town, State, Zi	p Code)
27 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Mrs. Deborah A. S	laysman (Wife)	627 Wal	ker Avenue, 1	Idlewyde			
IMOTE, Pages 1 at nent of Hea nut: If item		20a. Method of Disposition 1 □ Burial 2 ☒️Xremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State בילים	e of Disposition (etery, crematory on ns Funer	Name of prother place) al Chapel	18/06		est Hil	own, State l, Maryland
baltimo permit. Pages Department of Important: If it	300	21. Signature of Funeral Service Licer	Letw	22. Name Peace 2325	and Address of Facility ful Alternati YORK ROAD, TI	ives Fun Lmonium	eral& Marvi	Crematic	on Ctr. P.A
		23a. Part1. Enter the dise et , or com shock, or heart failure. List only	plications that caused the death. If	the second secon					Approximate Interval Between
Physicial		Immediate Cause (Final disease or condition	Hepatocellula	ar Can	ncer				Onset and Death
/Medica Examine		resulting in death)	Due to (or as a consequen	nce of):					3
		Sequentially fist conditions,	b Due to (or as a consequen	ice of):					
uted f ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
exection and rial-tra	Exa	resulting in death) Last	Due to (or as a consequen	nce of):					
icate be executed physicien and sthe burial-transit	dicai	•	d						
.U. BOX 68 fou, the death certificate be execut y the attending physicien and ched for use as the burral-tran	l o	IF FEMALE:	23c. ff yes, outcome of pregnancy					00 1 D-11 1-5	
BOX 60 eath certific attending p	sian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal de	ath 3□Ectopi	c pregnancy (specify)			23d. Date of deliv Month	Day Year
at the de by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ U⊓known	9☐Unknown						
- E D 0	by P	Part fl. Other significant conditions	ontributing to death but not resulting	ng in the underlyir	ng cause given in Part I.	23e. Di	d tobacco u	use contribute to	the cause of death?
ords en sig	pet					- 10	Yes 2	□No 3□Pro	babły 4 X Unknown
HECORDS, he faw requires t e has been signe	Completed					24a. W	topsy	prior to co	opsy findings available ompletion of cause of
	Con					pe 1□ Ye	rformed?	death? 1 ☐ Yes	2.™ No
VITAL P sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitaf:		Othor	eath (Check on			
hys this	2	1 ☐ Yes 2 ☑No 27. Manner of Death	Impatient 2UER	VOutpatient 3 3b. Time of	28c. fnjury at Work?	Home 5 Re 28d. Describ		6 ☐Other (Spec.	<i>fy</i>)
on ading th. Afte	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	In j ury M	Work? 1 ☐ Yes 2 ☐ No				
DIVISION OF I or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 Suicide 6 Could not be determined		e, farm, street, fac	ctory, office		Street an		ral Route Number,
DI tal or rs afte al Dir	Cert	4 - Homicide	Duilding, Stc. (Opecity)			0.0, 0		·	
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		hysicien: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death occur n and/or investiga		ice, and due to the curred at the time	ne cause(s) e, date and) and manner as d place, and due	stated. to the cause(s)
To the Complex complex	Σ	29b. Signature and title of certifier	MS		29c. License number		29d. Da	te signed (Month	, Day, Year)
0		Wes UR	_		0885 +802		Apr	11 18, 2	.006
41		30. Name and address of person who	completed cause of death (Item 23	3a) (Type, Print)	Brade	Saltinas	. M	00.10	71771
l 100 100 100 100 100 100 100 100 100 100	State	31. Date filed (Month, Day, Year)	32. Resistrar's Signatur	0 TV	-10-10-1015) / (niguma	016-1
Regi		APR 1 8	2006 Regue 1	1: Acen	Les .				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Weldon Louis Simpson 7, 2006 4:30 a April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Oct. 30, 1942 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**⊋**M 2□F 63 240-64-6303 Director N.C Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at N.Y. King Co Brooklyn X□Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1325 Pacific Street #4 11216 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a nand Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Black Completed 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clergy Minister 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Simpson Octavia Mintz ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ant: If item 27 is ury or other traus 1325 Pacific St.#4 Brooklyn, N.Y.11216 Wife Elsie Simpson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Depertment of Important: If eny injury or 2002. Rose Hill Cem. Apr.13,06 Linden, N.J. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hunt Funeral Home 908 Kennedy St.N.W.Wash.D.C.20011 Approximale Interval Belween Onsel and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 10 givator **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner roxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine is been signed by the attending physician and should be deteched for use as the burial-transit The law requires that the death certificate be executed ms that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnanl at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sl 2 No 1□ Yes 2√No 1 TYes or Attending Physician: : After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 1X☐ Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Chack only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 40 00029896 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Sunntli Rul Clinton CARLOS CIHALBOG & 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 200\$ Registrar

DHMH 17 Rev 1/2001

ORIGINA

			1 - For State Registrar	State o	f Marylan		artmen rtificat			and M	ental Hy	giene Reg. No.	006	5	12163
	Discosia:		Decedent's Name (First, Middle,	Last)							2. Date of De Month	eath Day	Ye	ear	3. Time of Death
	Physici /Medio		PEARL	_5	TONEBA	CAKE	2				04	16		06	6850 M
	Examir		4a. Facility Name (If not institution, g	give street and nu	m <i>ber</i>)	40	4b. City,	Town, or	Location o	of Death		4c. 0	County of I	Death	
			JOHNS HOPKINS	Briview					T)m						
	Funeral			.Sex 1 □ M 212 P	7. Age (In yrs. I		If Under Months	1 Year Days	If Under :	Min	8. Date of Bir (Month, Da	rth ay, Ye <i>ar)</i>		Count	
	Director		219–20–8405	1C W 2K	87	7 Yrs.					February	7 27,19	19 W	est	Virginia
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City	, Town or Lo	cation							10	d. Inside City Limits
	anyla	5													1 ☑ Yes 2 ☐ No
	Ne N	Directo	Maryland N/A		Bo	altimo	10f. Zip	Codo				10a Citiz	en of Wha	t Court	
	Mith De C	ā	3523 Esther Place	^			101. 21	212	24			-	SA	at Count	ay:
	s 23	Funeral			edent Ever in U.	c 12	Mas Dam			nin2 (Sne	ody Vac or N		4. Race -	America	an Indian
	ab re:	Ē	11. Marital Status 1 □ Never Married 2 □ Married	Armed F	orces?	3. 13.	If Yes, spe	cify Cuba	n, Mexican	, Puerto	cify Yes or No Rican, etc.)			White, e	
5	rs af	by F	3℃ Widowed 4 □ Divorced	If Yes, G	VO		1 🗆 Yes	2 X No	Specify:				SpecifyWl	nite	!
215-0036	d within 72 hours after deeth with the Maryland plans.	ed	15. Decedent's			16a. Dece	dent's Usua	al Occup	ation			16b. Kin	d of Busin	ess/Ind	ustry
<u>.</u>	n 7	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College ((Give	kind of wo DO NOT u	rk done d se retired	during most ()	t of workii	ng				
7 7		E	7 years	College (1.401 34)	н	ousew	ife				Own	Home	9	
0	鲁 美 美 美	BeC	17. Father's Name (First, Middle, La	ist)					18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)		
<u>a</u>	77 5 0 12	To B	George Nottingha	m					Nim	mie	Talber	t			
Maryland	should Ind Men	J-	19a. Informant's Name/Relationship			1					l Route Numb				
	ss 1 and 2 should of Heelth and Me I Item 27 Ia mark r othar traumatic		Roger L. Sanson	S	on	7309	Conl	ey S	treet	, Ba	ltimor	e, Ma	rylaı	nd 2	1224
ē,	of Hee		20a. Method of Disposition		· ·	lace of Dispo	sition (Nai	me of other plac	(e) Z	prif	ate 9	20c. Loc	ation - Cit	y or To	wn, State
Ē	Pages net: If it iry or o		1 ∑Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			rkwood			' '	200		Nott	ingha	am,	MD.
altimore,	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service Lie	cenigee (!	2	2. Name ar	nd Addres	s of Facilit		me Of	Dunda	11 D	Λ	
ñ	e de la companya de l		John 5 ml	81.		7	onnei 110 s	olle	ers Po	int.	Road,	Dunda	lk Mo	d. 2	1222
			23a. Rav1. Enter the disease, or or	omplications that	caused the death										Approximate Interval Between
	Dhusisian		shock, or heart failure. List or Immediate Cause (Final	_			- 00								Onset and Death
). ·	Physician /Medical		disease or condition resulting in death)	- a.	(or as a consequ		1100	,							
	Examiner				STROKE	_									4 Navs
		ē	Sequentially list conditions, larly, leading to larte solutions cause. Enter Underlying Cause (Disease or injury		(or as a consecu					-					1 24 (2)
	uted d ansit	Examin	Cause (Disease or injury that initiated events	c. 4	-R - L	FIRE	LLATI	ON						- 2	LO YEARS
,	exec en an rial-tr		resulting in death) Last		(or as a consequ										
8/60	certificate be executed thing physicien and ise as the burial-transit	dical		d											
٥	tifical ig ph as th	edi		7											
ROX	eath certific ettending pi for use as l	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		⊒Ectopic p	reon and	,			2	3d. Date o		•
	death e etter ed for u	cia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Preg	nant at time of de		Other (sp						Month		Day Year
J.	by the detected	hys	9 Unknown	9□ Unkr	iown						-				
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ğ	w require been sig should b										10	Yes 2.]No 3[☐ Proba	abiy 4 □Unknown
ပ္က	law re	piet									24a. Was		24b. Wei	re autop	osy findings available
Vital Records,	o	Completed									auto perf	ormed?	dea	ith? Yes	
ī	ician: Th certificate rector, peg	a	25. Was case referred to medical						26. Place	of Death	(Check only				
⋝	S w D	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 D	Oth	er: 4 🗆 Nu	irsing Ho	me 5 Res	idence 6	Other	(Specify)
Division of	ding Ph h. After thi funeral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	of 2	28c. Injur Wor	y at		28d. Describe	how injury	occurred		
Ö	Attending r death. sctor: After by the fune	atic	1 Natural 5 Pending 2 Accident investiga	tion	,,	,,	М		Yes 2 🗆	No					
<u>></u>	or Atten after deat Diractor: in by the	Certification;	3 Suicide 6 Could no 4 Homicide determin	200. Plac	e of Injury - At ho ling, etc. (Specify		reet, factor	y, office				(Street and	Number (or Rural	Route Number,
٥	rs after el Dira ed in b	Cer													
1	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edicai	2 Certifier 1 Gertifying (Check only 2 Medical E	Physician: To the kaminer: On the I	e best of my knic	wledge, deat	h conjuraci	at the ti	na date an	d place o	and due to the	date and	and mann	or as sti	the cause(s)
	To the H Within 24 To the F complete	edi	one)	and mai	ner stated.										
1	Son do	Σ	29b. Signature and title of certifier	-			29		e number			29d. Date	signed (/	Month, [Day, Year)
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	h		30. Name and address of person w	ho completed cau	se of death (Item	1 23a) (Type,	Print)			- ^	LTIMO				
	2		ROBERT HOETH	mb c	CO NOT	TH: 430	ù.∓¢	STI	HET	BA	LTIMO	RE 1	ni	21	48.7
100.		ate	31. Date filed (Month, Day, Year) APR 1 8	2006 320	Registrar's Signa	ture	ade s								
	Regist	rar	WINT O	LUUU JA	12650 8	19.13									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Dolores Swo.boda <u> April</u> 2006 4:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2504 Lakeview Avenue Edgemere Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 219-18-1492 January 28, 1925 Director 81 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Mudical Examiner must be notified at Director Maryland Baltimore Edgemere 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21219 2504 Lakeview Avenue USA "natural", or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iter Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specity: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Services 12 years years Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Milton Cramblitt Agnes Gomoljak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 2504 Lakeview Avenue, Edgemere, Maryland John Swoboda Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 20, permit. Pages 1 Department of H Important: If ite any njury or ot once 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial Park 2006 Halethorpe, Maryland 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the ceath, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, terval Between Interval believe... Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physicien Physician/Medical use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes ဥ 2 | Ne 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □ Other (Specify) this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident I Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, Registrar's Signature 31. Date filed (Month, Day, Year) State APR 1 8 2006 Registrar

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2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 30PM Smith 3 in 2006 Milton Apri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Balhmuccity Medical Center Mercy 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-23-41 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Yrs 217-38-0998 Director Md. 64 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow ir than "natural", or Items 23a or 28a-f ehov The Madical Examiner must be notified at 1√2 Yes 2 □ No Director Md. Baltimore NA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4611 Hazelwood Ave. 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In institute in the 27 is marked other than "natural", or itel any njury or other traumatic event, the Madical Examinat 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No δ Specify: Black 3 ☐ Widowed 4 X Drvorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Varies 8th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mike Davis Elizabeth Smith Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyliss Smith Daughter 1237 Linworth Avenue Apt. 2A, Baltimore, Md. 21239 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-19-06 Mt. Carmel Cem. Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. W ane 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** alomyopamy year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner been signed by the attending physicien and should be detached for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ventricular thrombus 1 Yes 2 No 3 Probably 4 Unknown Completed hypernatremle 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed? sepital or Attending Physician: Ti hours after death. ineral Director: After this certilicate y filled in by the funeral director, pa 1 ☐ Yes 2□ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours af To the Funeral Di Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Resident Physician 3/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DNVG Srikumavan 301 St. Paul Place Baltimure MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 1 8 2006

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			1 - For State Registrar	State of Maryla		artment of rtificate o			Reg. No.	12167
1000	Physici	an	Decedent's Name (First, Middle, Last)		,	~ '		2. Date of Do	Day Y	3. Time of Death
	/Medio		Edna	М.		Smith		04	12 20	
€. ***	Examir	ner	4a. Facility Name (If not institution, give s	treet and number)	silal	4b. City, Town	n, or Location of		4c. County of	Death
- 4 ₀			Gover sum es	1700 TOS	DITECT	If Under 1 Ye	- / / .	nore	NA	Birth
*	Funeral Director		214-12-4330	M 2 XF 87	s. last birthday, Yrs.	Months Da		Min. (Month, D.	ay, Year) 16–18	O. Birthplace (State or Foreign Country) Md.
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
	B Maryl	ctor	Md. NA		Balt.	imore				1¶Yes 2□No
	with the	Funeral Director	10e. Street and Number 2706 Southern Av	renije		10f. Zip Cod	1214		10g. Citizen of What USA	at Country?
	ne 23	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent	of Hispanic Origi	in? (Specify Yes or N Puerto Rican, etc.)	0- 14. Race -	American Indian,
36	be filed within 72 hours after death with the Maryland stal hygiene. Id other than "naturel", or Iteme 23a or 28a-f ehow event, the Midfrel Est idner must be published at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify C		Puerto Rican, etc.)	Black, Specify:	White, etc. Black
215-0036	2 hou	ed	15. Decedent's Educ	·	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Busin	ness/Industry
15	IIO 72	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give	kind of work do DO NOT use re	ne during most (of working		
212	with pieces	Completed	12th grade	College (1-4or 5+)	Priv	vate Dut	y Nursi	.ng	Other P	eople Homes
Maryland :	should be filed within a Mental Hygiene. marked other than matic event, the Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Last)	Henry M	cGlotte	en		's Name (First, Middle Clara	·	nedy
ягy	shou nd M mar	-	19a. Informant's Name/Relationship (Typ		19b. Maili	ng Address (Str	eet and Number	or Rural Route Numb	er, City or Town, Sta	ate, Zip Code)
-	atth a atth a 27 le		Irene Dozier	Daughter	240	9 Bridge	ehamptor	n Dr., Balt	cimore, Mo	3. 21234
ore,	of He		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other	place)	Date	20c. Location - Cit	1
Ĕ	Page nent ant: If		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State		s Mem. I		4–18–06	Arbutus	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked eny Injury or other treumatic e QDCs.		21. Signature of Funeral Service License	Ware			dress of Facility .H. East		imore, Md. E. North	
	Physician /Medical Examiner	16	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	e cause on each line. Sep. Due to (or as a conse	S/S			ardiac or respiratory a disc		Approximate Interval Between Onset and Death
ox 68760,	Attending Physician: The law requires that the death certificate be executed in death. If death. ector: After this certificate has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-fransit.	Medical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	Due to (or as a conse	equence of):	fi br	illay	404		
о. В	at the death certific by the attending p tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Lives, outcome of preging 1 Pregnant at time of 9 Unknown	tal déath 3[□Ectopic pregna □ Other (specify)			23d. Date of Month	
Records, P	uires that signed b	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	enderlying cause	given in Part I.			ute to the cause of death? Probably 4 □Unknown
Ö	w require been si should l	lete	rypercipia	enia.	upher	- aast	TOINE	65 = 24a. Was	an 24h We	re autopsy findings available
	ysician: The lav is certificate has director, page 2:	Completed	Tinal blee	ding, co	plery	cance	T, dep	auto	psy prio	or to completion of cause of th? Yes 2 □ No
=	i ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othor	of Death (Check only		
o	Phys this al dir	. To	1 Yes 2 No	Inpatient 2	ER/Outpatie	III SEI DOA		sing Home 5 Res		(Specify)
L C	ding F	lo	Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njuryat Work? I∏Yes 2 □ N		how injury occurred	
Division of Vital	i Pire	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st			28f. Location	'Street and Number wn, State)	or Rural Route Number,
_	Hospitel 4 hours Funerel lely filled	edical Ce	29a. Certifier (Check only one) Certifying Physical Examin	ician: To the best of my kr ler: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the	e time, date and ny opinion, death	place, and due to the n occurred at the time,	cause(s) and mannedate and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of certifier	0 4			ense number		29d. Date signed (/	
)	. 270		Mun	Ky MI		RF	5-000		4-12-	06
	. 0		30. Name and address of person who con	mpleted cause of death (Ite	em 23a) (Type.	Print)		_		21239
- (0		Dmitri Sonzo		, 56	501 Le	och Ra	iven BC	uch, Bai	14 invoice, MD
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Sign		ande				

DHMH 17 Rev 1/2001

Smith, Edna

			partment of Health and Mertificate of Death	Reg.	
Physic		Decedent's Name (First, Middle, Last) RUBY LEE SCOTT		2. Date of Death Month APRIL 15	Day Year 3. Time of Death 7:31a M
/Med Exam		4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL	4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGE'S
Funera Directo		5. Social Security Number 216 201 42-0618 Clark 1 M 2 K	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 12-2-19	9. Birthplace (State or Foreign Country)
ne Maryland Ba-f show	Director	10a. State 10b. County 10c. City, Town or MD. PRINCE GEORGE S BELTSV	ILLE		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
h with th		11516 CORDWALL DR.	10f. Zip Code 2 07 05	10g.	. Citizen of What Country? USA
72 hours after death with the Maryland 72 hours after death with the Maryland netural', or tlams 23a or 28a-f show Jical Examination of the periodities of the period	by Funeral		3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
within ane.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of worki by DONOT use retired ONNEL SPECIALIST	ing	b. Kind of Business/Industry
be filed that Hygic ad other went, II	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Mai	
ie, Inial ylain s 1 and 2 should be f Health and Mental item 27 is markad o other treumatic eve	2	HINTON SANDERS 19a. Informant's Name/Relationship (Type, Print) 19b. M.	EULA H ailing Address (Street and Number or Rura		ity or Town, State, Zip Code)
			16 CORDWALL DR. BEL	-	
00-		1 Burial 2 □ Crempation 3 □ Removal from State cemetery, of	rematory or other place) COLN CEMETERY 4-24-	115	c. Location - City or Town, State RENTWOOD MARYLAND
permit. Page Department Importent: If any injury or		21. Signature of Fundatal Service Licensee JONATHAN D. HIBN	PR Name and Address of Facility PHI	LLIPS FUN	
Physician /Medica Examine Examine the private and the private Italians t		shock, a heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) Sequentially list conditions. Tarry, Learn 3 to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	RE		Interval Between Onset and Death
that the death certificated by the attending plucated for use as t	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Se ug	þ	Part II. Other significant conditions contributing to death but not resulting in the CORONARY ARTERY DISEASE	e underlying cause given in Part I.		co use contribute to the cause of death? 2 No 3 Probably 4 Sunknown
e taw re has bee	Completed	DIABETES MELLIUS		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
sicien: The law requir certificate has been si rector, page 2 should I	0	HYPERTENSION 25. Was case referred to medical	26. Place of Death	1 Yes 2	
Phy r this	atlon: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 1 Accident investigation	of 28c. Injury at	me 5 Residence 28d. Describe how i	e 6 Other (Specify) injury occurred
tel or Attending s after death. al Diractor: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, state)
To the Hospitel or At within 24 hours after or To tha Funeral Dirac completely filled in by	ledical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do and manner stated.	eath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the caus ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To the within 2 To tha complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
1		30. Name and address of person who completed cause of death (Item 23a) (Ty)	N D013687	A	APRIL 17, 2006
5		JOSELITO D. MAGDAY, MD 11701 ROBY	, AVE. BELTSVILLE,	MARYLAND	20705
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 8 2006 32. Degistrar's Signature	hade !		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death APRIL 15, Day 2006 Year Physician SCHONFIELD 5:43 Ам TILLIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE 3198 OLD POST ROAD #7 | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | OCT | 13, 1915 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F MD 90 Yrs. 216-03-4883 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 🎇 No BALTIMORE Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3198 OLD POST ROAD #7 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify: δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: if item 27 is marked other t jury or other traumatic evant, iii 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SNYDER WILKINS SAMUEL REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health at Important: if item 27 is eny injury or other trains 200. EDITH MOSES / SISTER 3525 BARTON OAKS ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY 04/16/2006 WOODLAWN, MD 4 ☐ Donayton ≠ 5 ☐ Other (Specify) Funeral/Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eprovosu /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical d for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the et d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗆 Yes 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has t irector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 204 Division of Vital Attending Physician: : After this certifical funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 🗔 XIo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No efter death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours eft To the Funeral Di completely filled in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed death (Item 23a) (Type d 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		R	ZUUU leg. No.	12170
4.00	Physici /Medic		1. Decedent's Name (First, Middle, La Michelle	si) Sparks				2. Date of Dea Month.		Year 2033 M
	Examin		4a. Facility Name (If not institution, give Mn) YEVSity of Mary)	e street and number)	al Center	4b. City, Town, o	Location of Dear	th	4c. County o	f Death
N.	Funeral Director		5. Social Security Number 6. S 217-80-8176		ge (In yrs. last birthday 44 Yrs.	Months Days	If Under 24 Hrs Hours Min		Year) , 1962	9. Birthplace (State or Foreign Country) Maryland
	the Maryland 28a-f ehow	ector	Usual Residence of Decedent 10a. State 10b. County Marylad Baltim 10e. Street and Number	ore	10c. City, Town or L				l0g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 📉 No
	h with	ai Di	2029 Wintergreen	Place		212:	37		U.S.A	•
036	be filed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or Itema 23a or 28a-f ehow event. The Medical Exart are must be notified at	by Funeral Director	11. Marital Status 1 Marital Status 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces' 1 X Yes 2 ☐ If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No		Specify Yes or No- to Rican, etc.)	Black	- American Indian, , White, etc. White
21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 Years	ducation ade completed) College (1-4or N/A	5+) (Give	edent's Usual Occup e kind of work done DO NOT use retired	during most of wo		16b. Kind of Bus	of Maryland
d 2	other other	0	17. Father's Name (First, Middle, Last		Decit	ctary II		me (First, Middle,		
ylan	should be ind Mental marked o	To B	Lawrence Edwin Sp	arks				hy Brenda		
Maryland	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (M/M Lawrence Edwi			ing Address (Street				State, Zip Code) 21237
	of Healt		20a. Method of Disposition		20b. Place of Disp			Date		City or Town, State
OE			1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr			rematory,		17/06	Catonsy	ville, MD
Baltimore,	permit. Page Department of Important: If eny injury or		21. Signatur, of Figheral envision ice	nsee	2	22. Name and Addre Miller-D 6415 Bela		neral Hom Baltimo	ne, Inc.	21206
	Physician /Medical		23a Pani. Ener the disease, or composite, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PUIM	ine. Inary er	nter the mode of dyir	ng, such as cardia	c or respiratory ari	rest,	Approximate Interval Between Onset and Death IOnours
	Examiner				s a consequence of):					
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	s a consequence of).					
œ,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequence of):					
68760,	sate be shysicia the bur	icai		d						
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy	1		23d. Date Mon	of delivery th Day Year
0	v requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	ren in Part I.			bute to the cause of death? 3 Probably 4 Unknown
al Records,		Completed						24a. Was a autop perfor 1 \(\text{Yes} \)	med? / de	Vere autopsy findings available for to completion of cause of eath?
Vital	9 G	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	ient 2□ER/Outpatie	ent 3 DOA Ott	or	eath <i>Check only</i> of Home 5 Resid		r (Spanity)
of	gr fe	ition: To	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, D		of 28c. Injur			ow injury occurre	
Division	at or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	286. Place of II	njury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C			t of my knowledge dot of examination and/or i tated.					
	To the comp	Σ	29b. Signature and title of certifier		MD.	29c. Licens	se number		_	(Month, Day, Year)
,	0		30. Name and address of person who	completed cause of					April	13,2006
1	1		Chi-Na Pak 2	2 S. Greene	St. Baltin	love, MD	21201			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 8 2006	32. Regis	trar's Signature	le s				

06-02494 Travis Sen-Tell	Tayl	Or	State of				ck Indelible Ink alth and Mental F	Hygiene	0000	
		1- For State Registrar			Cei	tificate of Dea	ath	Reg.	No. 2006	1211
Physicia Medical Exami	an/	1. Decedent's Name (First, Market Facility Name (if not inst 2878 Scarborough	Se itution, give st	n tell reet and number)	7		y, Town, or Location of Dea podlawn	April 11, 200	Ac. County of Death Baltimore Cou	
Funeral Director		5. Social Security Number 222-64-064	6. Sex		(In yrs 18 24		nder 1 Year If Under 24H nths Days Hours Mi		,	thplace (State or Foreignatry) aryland
any		Usual Residence of Decede 10a. State 10b. Cou		1	I0c. City,	Town or Location				10d Inside City Limit
nd show:	Ĕ	Maryland	NIA		R	altimo	SP			1 Yes 2 N
taryla 28a-f	Director	10e. Street and Number	14/1			10f. 2	Zip Code	10g	Citizen of What Cour	ntry?
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If if them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral Dir	3002 S 11. Marital Status 1 Never Married 2	Pau	2. Was Decedent E Armed Forces?	-4	S 13. Was Dece If Yes, spe	2 (2/5 edent of Hispanic Origin? (S acify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
after c	by F	3 Widowed 4	Divorced If		X 110	1 Yes	2 No specify		Specify:	ack
hours :	ed b	15. Decedent's Education	(Specify only	highest grade comp		16a. Decedent's Usu during	ual Occupation (Give kind of	work done 1	6b. Kind of Business/I	ndustry
D 21215-0036 should be filed within 721 and Mental Hygiene 7 is marked other than "y natic event, the Medical Is	Completed	Elementary/Secondary (0		College (1-4 or 5-	+)			ne (First, Middle, Ma	den Surname)	
121 d be fi lental arked event,	o Be	James	N.	laylor			Cap	athla	Will	iams
MD 2 d 2 shoul lth and M n 27 is m	۲	19a. Informant's Name/Rela	tionship (Type	Print) 1 (Sis	ster)	19b. Mailing Addre	ess (Street and Number or	Rural Route Number	er, City or Town, State	, Zip Code)
e, M l and 2 Health item 2		20a. Method of Disposition	110	raylor		Place of Disposition (N		Date 2	Oc. Location - City or	Town, State
nord			ation 3	Removal from Stat	" 1/	rematory or other pla	DOCK 4/	19/2006	Ratto	MA
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		4 Donation 5 Other 21. Signature of Funeral Ser	er Specify: vice Licenses	2.0	111	ng Men	nd Address of Eacility		Dallo.	0.0
Dep Dep (D)		Caroph	X	Trus	1	Josep	W. North A.	re Bar	d Home, to. Nd. 212	
Physician		23a Part I. Enter the disease	e, or complica	itions that caused the	ne death.	Do not enter the mod	de of dying, such as cardiac			Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final dis	ease a. Mu	ultiple Sharp F						Death
•		or condition resulting in dea	, ,	e to (or as a consec	quence o	f):				
	jer	Sequentially list conditions, if any, leading to immediate		e to (or as a consec	quence o	f):				
	Examiner	cause Enter Underlying Ca (Disease or injury that initial	ted C.	a ta (ar ea a canaac		F).				
ted d ansit	Exa	events resulting in death) L	ast Du	e to (or as a consec	querice o	r):				
execution and and all - train	ical	UNPENDED		AMENDED						
60, ate be hysici	Physician/Medica	IF FEMALE:		23c If yes, outcome	e of pregi	nancy			23d. Date of delivery	
Box 68760, e death certificate be the attending physic ed for use as the burned for use	an/I	23b. Was decedent pregnant past 12 months?	in the	1 Live birth		2 Fetal dea	th 3 Ectopic pregr	nancy		Day Year
OX (eath or attenution	Sici	1 Yes 2 No 9	Unknown	Pregnant at ti Unknown	ime of de	ath 5 Other (S	(pecify)			
P.O. es that the igned by		Part II. Other significant co			but not re	esulting in the underly	ing cause given in Part I.		cco use contribute to	the cause of death?
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should t	Completed by							24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of second 2 No
tal Frian: certifi ector.	Be (25. Was case referred to me examiner?		-:4-1			26.Place of Death (Check	, ,		
F Vir Physic rrthis	2	1 ✓ Yes 2 No	HOS	pital: 1 Inpatien		ER/Outpatient 3			sidence 6 🗸 Other	Scene
n O' iding h h : Afte	on:	27. Manner of Death 1 Natural 5	Pending	28a. Date of Injury FOUND:	/ ar)	28b, Time of Injury FOUND:	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how Subject stabb		
Division tal or Attendin rs after death all Director: A	Certification:	2 Accident	Investigation	Apr 11, 2006	irv - At bo	2359 hrs	ory, office building, etc.	29f Location (Stro	act and Number of Du	and Florida Niverbay City
Divi	ř		Could not be determined	(Specify) resid	-	ome, iaim, sireei, iacio	ory, office building, etc.	or Town Stat		ral Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death To the Funeral Director: After this certificate I completely filled in by the funeral director, page		29a Certifier 1 Cortifui		-		de, death occurred at	the time, date and place, an			
thin 2. othe F	Medical		Examiner: O	n the basis of exam			my opinion, death occurred			
T w	Me	29b. Signature and title of co		nd manner stated		2	29c. License number	2	9d Date signed (Mor	nth, Day, Year)
		tox: 1	1,00	n. c. t	200	oh .~	O.C.M.E.	,	April 12, 2006	
		30. Name and address of pe	rson who con	npleted cause of de	ath (Item	23a)				

Registrar



Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 10/2003

				Department of Health and Mental Hygiene Certificate of Death Rag, No.	12172
	Physici /Medic		1. Decedent's Name (First, Middle, Last) James	2. Date of Death Month Day Year April 14 2006	3. Time of Death
	Examin Funeral		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bin		łace (State or Foreign
	Director		Usual Residence of Decedent	FIG 3, 1925 / IZAN	SYLVANIA
	ne Marylar 8a-f show	ctor	10a. State 10b. County 10c. City, Town 10a. State 10b. County 10c. City, Town	m or Location	0d. Inside City Limits 1 ☐ Yes 2∰2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28a-f show eny injury or other traumatic event, The Modical Examiting must be notified at ODEs.	Funeral Directo	10e. Street and Number 10A QALLAS LOUAT 11. Marital Status 12. Was Decedent Ever in U.S.	10f. Zip Code 10g. Citizen of What Count 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
9800	rel', or iter	þ	Armed Forces? 1 □ Never Married 2 □ Married 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, e 1□ Yes 250 No Specify: Specify:	etc.
21215-0036	within 72 h ene. then *natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TETIS WORK 16b. Kind of Business/Ind	•
land 2	should be filed within nd Mental Hygiene. marked other then ' imatic event, I're M.	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname) HSLs \ VAFSAC	(1/2/25T
, Maryland	and 2 shou salth and M n 27 Is mar ier traumat		19a. Informant's Name/Relationship (Type, Print) 19b.	D. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip	(ARY LAND
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		20a. Method of Disposition 128 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	f Disposition (Name of ry, crematory or other place) APRILIA 20c. Location - City or Tow	wn, State
Ball	permit Depart Import eny in		21. Sign the Funer Service Ticensee	22. Name and Address of Facility of MEMORIES EVANS HARFORD ROED PARKY, LIE (JARYLAN
	Pnysician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	3	Approximate Interval Between Onset and Death O CayS
	Examiner	Jer.	Due to (or as a consequence of Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of the conditions).	astic syndrome	years
,0	sate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	of):	
Box 68760,	entificate b ding physic se as the bi	Medica	d		
P.O. Bo	The law requires that the death certificate be executed the has been signed by the attending physician and rage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	ry Day Year
	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in pulmonary hypertension, ren	n the underlying cause given in Part I. 23e. Did tobacco use contribute to the	N/
Division of Vital Records,	: The taw ricate has be page 2 shi	Completed	cardiomyopathy, atrial fit	autopsy prior to comperformed? death?	sy findings available apletion of cause of
of Vita	Physicien this certifi ral director	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No		
/ision	Attending Physicien: It death. ector: After this certifice by the funeral director, p	Certification:	1 Natural 5 Pending (Month, Day Year) In 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far	njury Work? M 1 ☐ Yes 2 ☐ No Irm, street, factory, office 28f. Location (Street and Number or Rural.)	Route Number,
ā	To the Hospitel or Attending Physicien; The twithin 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical Cert	4 Homicide building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only 2 Medical Examiner: On the basis of examination and	City or Town, State) a, death occurred at the time, date and place, and due to the cause(s) and manner as stated/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of the course	ited.
	To the Ho within 24 To the Fu	Medi	one) and manner stated. 29b. Signature and alle of certifier	29c. License number 29d. Date signed (Month, D.	
	d		30. Name and do of person who completed cause of death (Item 23a) (06
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 1 8 2006	10 North Wolfe St; Baltimore MD 2	1681

		1 - For Stete Registrar	State of Maryland	-	artment of Heatificate of De			ene)	06	12173
Physici	an	1. Decedent's Name (First, Middle, Las	•				Date of Deat Month	Day	Year	3. Time of Death
/Medic		Frances Leola Tu					April	14	2006	2:15 A. M
Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo				y of Death	
		Good Samaritan N 5. Social Security Number 6. S		st hirthday)	Baltimore		8. Date of Birth	1	I/A	lace (State of English
Funeral Director			□M 2)DF 88	Yrs.			(Month, Day, Aug. 24,	1917	Orec	lace (State or Foreign try) JON
yland		10a. State 10b. County	10c. City,	Town or Lo	cation		·		1	0d. Inside City Limits
the Mar. 28a-1 et	ector	Maryland N/	'A Bal	timore	City		11	g. Citizen of	Minet Cours	1 ∑Yes 2 ☐ No
3a or	ī	3707 Woodlea Av	enue		21206		''	United		•
death	era	11. Marital Status	12. Was Decedent Ever in U.S	i. 13. y	Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spec	cify Yes or No-	14. Ra	ce - Americ	an Indian,
IZ I 3-UU30 within 72 hours after death with the Maryland ane. ane. then 'naturel', or iteme 23e or 28e-f ehow the Marilast Examiner must be notilised at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes ②○XNo If Yes, Give Year or Dates:		37	Mexican, Puerto F Specify:	lican, etc.)		ick, White, ^{fy:} Wh i t	
Z I 3-0030 Ithin 72 hours aft ie. "nature!", or Madical Exemi	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	ent's Usual Occupatio kind of work done during OO NOT use retired)	n ng most of workin	g	6b. Kind of B	Business/Ind	dustry
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d be filed ontal Hygi sed other	To Be Co	17. Father's Name (First, Middle, Last) Earl Ronald Fro				Mother's Name			пө <i>)</i>	
; Maryland and 2 should be file saith and Mental Hy n 27 is marked oth	F	19a. Informant's Name/Relationship (1 Mrs. Darlene M.			g Address (Street and			,		/
BAITIMORE, MARYJANG 21215-0036 permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23e or 28e-1 ehow appringing or other traumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition 1 Burial 2 Oremation 3 4 One 5 Other (Specify	Removal from State	ace of Dispo	sition (Name of natory or other place) neral Chape	ill Da	ate 2	Oc. Location	- City or To	
Baltil permit. P Departm importar any inju		21. Signature of Funeral Service Licen		Pe	Name and Address of eaceful Alt 25 York Ro	f Facility cernative	es Funer	al&Cre	matic	n Ctr.,P.
death certificate be executed We death certificate be executed Exx We did not use as the burial-transit If the provided in	Ical Examiner	23a. Part1. Enter the disease for companies shock, or heart failure. List only of the shock of t	a. Due to (or as a conseque Due to (or as a conseque Due to (or as conseque C. A Due Due to (or as conseque d.	ascl ence of): Merce of):	II.	accio	[] [/			Interval Between Onset and Death
death certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome of pregnanting the state of the stat	death 3	Ectopic pregnancy Other (specify)				ite of delive	ry Day Year
uires that the derisigned by the e	è	Part II. Other significant conditions or	ontributing to death but not result	ting in the ur	derlying cause given in	n Part I.		acco use con	tribute to th	e cause of death?
The law requires that the set has been signed by the page 2 should be detached.	Completed						24a. Was an autopsy perform	ed;?	prior to con death?	psy findings available apletion of cause of
ysicien: The ris certificate director, pag	Bec	25. Was case referred to medical examiner?			26	. Place of Death		0		7
_ × × 5	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	3 DOA Other:	4 Nursing Hom	e 5 🗆 Resider	ice 6 Oth	ner (Specify)
Attending Ph r death. ector: After th by the funeral		27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		3d. Describe hov			
DIVISION Itel or Attending rs after death. all Director: Afte ed in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)				Bf. Location (Str. City or Town,	State)		
To the Hospitel or Attending I within 24 hours after death or To the Funeral Director: After completely filled in by the funeral completely filled in the funeral completely f	Medical	one)	vsicien: To the best of my know iner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the time, o estigation, in my opinio	date and place, ar on, death occurred	nd due to the car d at the time, da	use(s) and ma e and place,	anner as sta and due to	ated. the cause(s)
To t To t	2	29b. Signature and title of centifier	Imperia	en	29c. License nu	3066 (A	d. Date signe pril	14 l	2006
4		30. Namerand address of person who o	ompleted cause of death (Item)	23a) (Type, I	Print) Balli	nore-	Fld	- 21	230	7
Sta Registr		31. Date filed (Month, Pay Year)	32. Rastrar's Signatu	re La	No.					

DHMH 17 Rev 1/2001

State

DHMH 17 Rev 1/2001 OCME 10/2003

Registrar

ORIGINAL

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

Patricia Arnica-Pollak MD.

APR 1 8 2006

31. Date filed (Month, Day, Year)

gue

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 12, 2006

		For State Registrar	State of Ma	rylan			nt of He			F	Reg. No	UUU	12175		
hysicia		Decedent's Name (First, Middle, Last	1)						2.	Date of Dea Month	Da	7, 2006	3. Time of Deat		
/Medica	al -	Robert Webb				45 03	. T			pril	1	2:30 F			
xamine	r	4a. Facility Name (If not institution, give	street and number)			46. Cit		ocation of De	atn		40	: County of Dear			
neral		29 Wends1ow Road Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth											NOTE thplace (State or For buntry)		
ector		215-28-1926 Usual Residence of Decedent	2M 2□F	75	Yrs.	Month	S Days	Hours Mi		(Month, Day pril 2			MD		
rthan "neturel", or Items 23a or 28a-f show the Medical Examinar must be notified at		10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Lin		
d (lec	Director	MD		Tim	onium								1 ☐ Yes 2 ♣		
20		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?													
Time!	Funeral	29 Wendslow Road	12. Was Decedent B	Superio II	6 12		21093		104	. V N -	r	USA 14. Race - Ame	dana ta dan		
T I	un l	11. Marital Status 1 Never Married 2 Married	Armed Forces?		.S. 13.	If Yes, sp	ecify Cuban	panic Origin? , Mexican, Pue	erto Ric	an, etc.)		Black, Whit			
	by	3 Widowed 4 Divorced	1 PYes 2 N tf Yes, Give Year or Dates:	~195 195		1 🗌 Yes	20 No	Specify: W	hite	е		Specify: W	hite		
	eg -	15. Decedent's Edi	ucation	19)	16a. Dece	dent's Us	ual Occupat	ion			16b. F	(ind of Business	/Industry		
Man	pie	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5	+)	(Give	DO NOT	rork do ne du use r <mark>etired)</mark>	ring most of w	rorking	ŀ					
#	Completed	12		,	Print	er					Bar	ton and	Cotton		
	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle,											
	2	George Webb						Elea	nor	Brady	7				
traumatic		19a. Informant's Name/Relationship (T	ype, Print)		19b. Maili	ing Addre	ss (Street an	d Number or i	Rural R	Route Number, City or Town, State, Zip Code)					
100	Į,	June Webb - Wife			29 W	ends.	low Ro	ad Tim	oniı	ım, Ma	ry1	and 210	93		
or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Damoval from State	20b. F	Place of Disponentery, cre	osition (N matory or	ame of other place)		Date		20c. L	ocation - City or	Town, State		
o Liz		4 Donation 5 Other (Specify,		Me	tro Cr	emate	ory In	ic. 04-	19,2	2006	Ba1	timore,	Maryland		
any injury or QDCB.		21. Signature of Funeral Service Lice	ch l-r	200	2	2. Name	and Address ation	of Facility C	еţу	of I	Mar	yland, ville,	Inc.		
	Ť	23a. Part. Enter the disease, or comp	lications that caused	the deat	h. Do not en	ter the mo	de of dying,	such as cardi	ac or re	spiratory ari	ONS rest,	ville,	Approximate		
		shock, or heart failure. List only of Immediate Cause (Final	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each time. Lung Concer										Interval Between Onset and Death		
ian ical		disease or condition resulting in death)	a			3 mont									
ner			Due to (or as a	Prised	juence or):										
4	ē	Tany landing to immediate	b. Due to (or as a												
		cause. Enter Underlying Cause (Disease or injury that initiated events													
	Examiner	resulting in death) Last	c. Due to (or as a	conseq	uence of):										
1	ca		d.												
3 4	8														
1	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				Tectoria arganav					23d. Date of del	livery		
	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									Month Day Yea			
	nys.	9 Unknown	9□ Unknown												
	Dy P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										bacco use contribute to the cause of death?			
3	0			1						☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow					
	Completed									24a. Was a	an	24b. Were au	itopsy findings availa		
	E	autopsy perform									med?	prior to completion of cause of death?			
	ပိ	25. Was case referred to medical						26 Place of D	eath /C	1 Yes		1 🗆 Yes	2.2 No		
0	0	evaminer?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										make)		
(H	- 1	27. Manner of Death	28a. Date of Injur (Month, Day		28b. Time o					me 5 KResidence 6 Othe 28d. Describe how injury occurre					
		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	М		s 2 No				,,4.,, 00041104			
1100	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, street, factory, office 2							28f. Location (Street and Number or Rural Route Number,					
1	e	4 Homicide	building, etc	(Specif	'y)					City or Tow	n, Stati	9)			
	edical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of iner: On the basis of and manner sta	examina	owledge, deat ation and/or in	th occurre	d at the time on, in my opir	, date and plantion, death oc	ce, and curred a	due to the cat the time, o	ause(s late an) and manner as d place, and due	stated. to the cause(s)		
	Mec	29b. Signature and title of certifier	and method Std				9c. License i	number			29d. Da	ite signed (Monti	h, Day, Year)		
İ		m. e2-0	our Kiding	e , n	10			1861	-			4/18/			
	-						~)	, , , , ,				1 1 10 10	6		
		30. Name and address of person who c	SZI N	eath (Iten	п 23а) (Туре,	Print)	n	actino		m 2	2.7	74) i			
		31. Date filed (Month, Day, Year)				ues	13	- in a	72	mel	21	~ /			
State gistra	_	APR 1 8 21	32. Fed istra	ıı ə əigna	No A	an elle	,								
ज्ञान्याच		n 1 1 7	(111) It was a		13 63	ESS CONTRACTOR									

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			1 - For State Registrar	State of N	Marylan		artmen rtificat			and M		giene Reg. No	UUU	12176		
	Dhusisi		1. Decedent's Name (First, Middle, L.	ast)							2. Date of Dea	ath Da	ay Year	3. Time of Death		
	Physici /Medi		Margaret Mary Warfi								Apri	/ /	1 2006	1426 M		
	Examir	ier	4a. Facility Name (If not institution, gi	ve street and number	ər) 		4b. City,	Town, or	Location o	of Death	,	40	c. County of Death			
			51 AGNES	MOSPI.	If Under	1 Year	If Under	24 Hrs	9 Date of Birt	h	n/a	Igna (State or Famine				
	Funeral Director								Hours	Min.	8. Date of Birt (Month, Da March	15 ear	1945 MD	lace (State or Foreign try)		
			Usual Residence of Decedent	A									1,117			
1215-0036 within 72 hours after death with the Maryland ene. than "natural, or Iteme 23a or 28a-f ehow than "Madical Examinar must be notitited at	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						1	Od. Inside City Limits			
	8a-f	cto	MD Baltimo	ore	Ba	1timor								1 ☐ Yes 2 ☐ No		
	Mith th	Dir.	10e. Street and Number	bod			10f. Zip	229			i	10g. C	itizen of What Coun	itry?		
	eath y	by Funeral Director	631 Aldershot Ro	12. Was Decede	ot Ever in II	6 112 1			enanio Orio	nio? /So	ecify Yes or No		USA 14. Race - Americ	an Indian		
10	Her d	Fun	1 Never Married 2 Married	Armed Force	s?	.3.	If Yes, spec	offy Cubar	n, Mexican	, Puerto	Rican, etc.)		Black, White,	etc.		
93	ursa al', ol		3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes	2 □X No	Specify:	wh	nite		Specify: Wh:	ite		
Maryland 21215-0036	72 ho	Completed	15. Decedent's 8 (Specify only highest gi	Education	16a. Dece			ident's Usual Occupation a kind of work done during most of worki			ina	16b. F	Kind of Business/Inc	dustry		
2	ithin	npi	Elementary/Secondary (0-12)					DO NOT use retired)			9		. 1 .	1		
2	Hiled w Hygier Sther ti										(First Middle	social Security Adm.				
and	uld be f fental h rked of tic ever	Be c	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)													
<u>7</u>	2 should and Men le marke eumatic	10	Elmer W. Warfiel 19a. Informant's Name/Relationship			19b. Mailir	na Address	(Street a						Code)		
N S	s 1 and 2 should be filed within 72 hours after death with the Marylan filed that had Member at Health and Member 1 bytener than "natural", or iteme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Kathleen Miller - Sister 935 Dunellen Drive Towson, MD 21286										, , ,	, 5.11.5, 2.15 5555,			
a)	s 1 a of Hea item othe		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	1 ~	Place of Dispo	sition (Nan	ne of	1		Date		ocation - City or To	wn, State		
E	Page nent c int: If iry or	1	1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Spec			ro Cre				1-12	7-06	Bal	ltimore,	Maryland		
Baltimore,	permit. Pages Department of H Important: If Ite any in ury or of once.	2. 3	21. Signature of Funeral Service Lio	A		22	Name an	d Addres	s of Facilit	у	. W1		T			
	80 E 2 9	V	23a. Part f. Enter the disease, or cor shock, or heart failure. List only	chlas	nge	1 29	enati 9 Fre	on s deri	ck Re	y or	Maryla Catonsvi	апа, i 11с	, INC. Marylan	1 21228		
			- , ,	Approximate Interval Between												
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Cara		monai		dist	7055					Onset and Death		
	/Medical Examiner		resulting in death)	,	as a conseq	uence of):	1200	n'n	ma					3		
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. <u>PSO</u> Due to (or	as a consed	uence of):	Cer	Ciru	mu					3 weeks		
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events													
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or	as a conseq	uence of):										
8760,	ate be executed hysicien and the burial-transit	dical		_ d												
	entifica ling pl	Med	IF FEMALE:													
Вох	death certific e attending p id for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Feta	Ideath 3□	Ectopic pr						23d. Date of delive Month	ry Day Year		
P.0.	0 0 0	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5∟	Other (sp	ecify)						,		
	requires that the de leen signed by the a hould be detached t	유										Did tobacco use contribute to the cause of death				
of Vital Records,	* D											1 Yes 2 No 3 Probably 4				
<u> </u>	s been significations of the state of the st	Completed									24a. Was	an	24b. Were autor	osy findings available		
æ	The law ete hes b page 2 sl	E O										rmed?	prior to completion of cause of death?			
ital		0	25. Was case referred to medical	•					26. Place	of Death	1 Check only one					
>	S 5	To B	examiner? 1 □ Yes 2 No	Hospital: 1 Inpa	atient 2 🗆	ER/Outpatien	it 3□ DO	A Othe	C 4□Nui	rsing Ho	me 5 ☐ Resid	ience	6 ☐Other (Specify)		
C C	Ing P	ë	27. Manner of Death 1 Naturat 5 □ Pending	28a. Late of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury		8c. Injury Work			28d. Describe h	now inju	iry occurred			
sio	Attending it death. ector: After by the fune	cati	Accident investigation 3 Suicide 6 Could not	ne -	M 1 □ Yes 2				es 2 🗆 N							
É	or At titler of Direct in by	Certification:	4 Homicide determined	286. Place of	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (S City or Tow	Street al vn, State	et and Number or Rural Route Number, State)			
_	To the Hospitel or Attending Phywitin 24 hours after death. To the Funerel Director, After th completely filled in by the funeral		29a. Certifier 12 Certifying P	hysician: To the be	st of my kno	wledge death	occurred:	at the time	e date and	d place	and due to the	nauco/c) and manner as et	atad		
	• Hos	edicai	(Check only 2 Medical Exa	miner: On the basis and manner	of examina	ition and/or in	vestigation,	in my op	inion, deat	h occurr	ed at the time, o	date an	d place, and due to	the cause(s)		
	To the within 2 To the Complet	¥	29b. Signature and title of certifier					. License					ate signed (Month, L			
			Co. Ry	Elm.	1	10		Do	056	143	3	4	1/12/01	2		
	1-		30. Name and address of person who WIRAYMOND ZHU	completed cause o	f death (Item	23a) (Type,	Print)	(A IA-	DAI		107	4~	11110			
	9		WIRAYMOND ZHU	DEPT PAT	HOLOG	Y. 400	CATON	AVE	. 13/11	. [[//]	UKG, N	1Do	xiday			
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 8	2006	strans Signa	ture	me	•								

War field, Margaret M.

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. Amend Item 10b per in 8544-18-06. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MAIKER torman 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown er 1 Year | If Under 24 Hrs. | 8, Dat alto nesi are 8. Date of Birth (Month, Pay, AUQ, 9. Birthplace (State or Foreign 5. Social Security Number (In yrs. last birthday) If Under 1 Year **Funeral** Days Months Hours -32-4710 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imprortant: if item 27 ie marked other than "natural", or iteme 23e or 28e-f ehow eny injury or other thatmatic event, I'm Medical Exprint must be notified at Baltimore 10c. City, Town or Location 10b. County 10a. Stale 10d. Inside City Limits 1 XYes 2 □ No Directo Marylana 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Yes 2 Yes, Give 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Slack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Worke d novernmen 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Brown 2 Orman (aunt) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Venic 20a. Method of Disposition 20c. Location City or Town, State rtamburg Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 23a. Part | Enter the Irease, or complications that cares the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease or condition resulting in death)

23 Name and Adversa I Facility

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Toseph L. Russ Funegal H

28 Name Son une cal Home P.H. ve. Balto. Md. 21216 Approximate fnterval Between Onset and Death Physician /Medical Examiner Congestice heav Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit ndStare renal the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant al lime of death 5 Other (specify) ☐Yes 2XNo 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 **N**No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hin 24 hours after the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 2 D 30 115 4/12/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bethmere mp 21215 Herrs itre Ohlokpehsi 1 hn 2600 Libert 31. Date filed (Month, Day, Year) APR 1 32. Registrar's Signature State 2006

DHMH 17 Rev 1/2001

Registrar

06-02357 Joseph William, S	Sr.	State	Please Type or Pri of Maryland / Departm	ent of He	alth and Mental Hy	giene		0000		: "7 ()
		- For State Registrar		cate of De		2. Date of De	Reg. No.	ZUUC	3. Time of De	1/8
Physicial Medical Examin	er	1. Decedent's Name (First, Middle, La	M. William		/, Town, or Location of Death	Month April 5, 2	2006 Day	Year	22:01	atn
Name of the same o		4a. Facility Name (if not institution, gi 819 Fremont Avenue		Bal	timore City	Data of I	B	altim	ore Ci	44
Funeral Director	c	5. Social Security Number 2.19.52-867 18 Usual Residence of Decedent	7. Age (In yrs. last bit		nder 1 Year If Under 24Hrs. The property of t	8. Date of	5-19		intry) Gry A	nc/
nd show any ice.		10a. State 10b. County	Ba L	or Location	re City				10d. Inside C	-
and ND 21215-0036 And 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. The should b	Funeral Director	10e. Street and Number 819 Frem	nont ave	10f.	Zip Code / / / / / / / / / / / / / / / / / / /		10g. Citizer	n of What Coun	try?	
r death with or items 2.	Funera	11. Marital Status 1 Never Married 2 Marrie	1 Yes 2 No	If Yes, sp	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto			Race - Americ White, etc.	can Indian, Bla	ack,
ırs after tural", iminer	ğ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	d If Yes, Give Yeer or Dates: only highest grade completed) 16a	. Decedent's Usi	2 No specify: all Occupation (Give kind of w	ork done		d of Business/li	ndustry	
1215-0036 d be filed within 72 hours after fental Hygiene. narked other than "matural"; event, the Medical Examiner.	Completed	Elemantary/Secondary (0-12)	College (1-4 or 5+)	most of workin	g life. DO NOT use retired)		Hor	neI	MArov	ement
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be Cor	17. Father's Name (First, Middle, Las	Williams		18.Mother's Name	(First, Middle	Maiden Su	irname)	mes	
e, MD 21215-003 1 and 2 should be filed withit Health and Mental Hygiene, 'item 27 is marked other th		19a. Informant's Name/Relationship	Type, Print) Sister 19	9b. Mailing Addr	ess Street and Number or F	tural Route N	lumber, City	or Town, State	Zip Code)	223
more, MI Pages I and 2 s nent of Health an ant: If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State Crema	atory or other pla	Name of cemetery,	Date	1	cation - City or	. 1 4	11
Baltimore, permit. Pages 1 a Department of He Important: If its injury or other t		4 Donation 5 Other Specification of Funeral Service Lice			nd Address of Facility	1115,2	106 1	Sivera	1081	UN TOTAL
Physician	6	23a, Pal I. Enter the dise se cross failure. List only one cause on o	plic tions that caused the death. Do reach line.	not enter the mo	de of dying, such as cardiac or	respiratory	arrest, shock	k, or heart	Approximat Between O	
/Medical Examiner			A. Hypertensive Atherosclerot Due to (or as a consequenca of):	tic Cardiovas	cular Disease				Dea	ath
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):							
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
e executician and	dical	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnanc 1 Live birth 4 Pregnant at time of death	y 2 Fetal de		incy		Data of dalivery fonth		Year
Box ne death the atte	3	1 Yes 2 No 9 Unknow	9OTIKIOWII			220 Di	d tabassa us	co use contribute to the cause of death?		
P.O.	Ď	Part II. Other significant conditions	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did to							
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the duthith 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed					pe	as an topsy of formed?	24b. Were au prior to death?	ompletion of o	
al Re an: Th ertifica	Be Co	25. Was case referred to medical			26.Place of Death (Check	only one)				
Vita hysici this c	ToB	examiner? 1 ✓ Yes 2 No		Outpatient 3	DOA Other Nursin			ce 6 Othe	: Scene	
ion of tending P eath. for: After the funers		27. Manner of Death 1 Natural 5 Pending 2 Accident Investig.	(Month, Day, Year)	o. Time of Injury	28c. injury at Work? 1 Yes 2 No	28d. Descri	oe how injury	occurred		
Divisipital or At ours after derail Direct filled in by	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)								
To the Host within 24 ho	Medical (29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	Ician: To the best of my knowledge, der:On the basis of examination and/o and manner stated.	death occurred a r investigation, it	the time, date and place, and my opinion, death occurred a	due to the cat the time, da	ause(s) and ate and place	manner as star e, and due to th	ted. e cause(s)	
A E 3 E 8	Me	29b. Signature and title of certifier	troe con		29c. License number O.C.M.E.			ate signed <i>(Mo</i>	nth, Day, Year,)
27			o completed cause of death (Item 23a tant Medical Examiner 11		et, Baltimore, MD 2120	1				
		31. Date filed (Month, Day, Year)	32. Registrar's Signature	houle	•					
Regist DHMH 17 Rev 1/2	_	APR 1 8 2	006 Blown B	RIGINAL						

DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene 🔒 🧎 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year GEORGE J. WATKINS, III 1:40PM 15,2006 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 19 Florida Avenue Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 3, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 1 XM 2 ☐ F Yrs. 75 Director 217-24-0780 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or Items 23a or 28e-f ehow the Medical Examiner must be notified at Parkville 1 Yes 2 No MD Baltimore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21234 8800 Walther Blvd. Unit 4310 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (∆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 te marked other than "n Elementary/Secondary (0-12) Baltimore Gas and Electric College (1-4or 5+) Supervisor 12 Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edna Mae Dacan George Watkins, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd.Unit 4310 Parkville MD 21234 19a. Informant's Name/Relationship (Type, Print) Item 27 Mary Watkins-Spouse 20b. Place of Disposition (Name of crematory crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott Dulaney Valley Mem. 1 Durial 2 □ Cremation 3 □ Removal from State 4-19-06 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS CHAPEL O Road-Parkville 8800 Harford ondrae Approximate Interval Between Oncet and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner S uential list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): anding physicien and use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending d be detached for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 0.0 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No of Vital Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) HCS P.C. 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after c 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of gertifie 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 31. Date filed/(Month, Day, Year) 32. Pagistrar's Signature State Registrar

				For State Registrar		State o	f Mar	yland /		tment of h		Mental Hy	/giene	UUD	12	18	0
				1. Decedent's Name (First, Middle, Last) 2. Date of Death												ime of D	eath
		Physicia		Rosetta Wrig								April	Da / 7	y Yea	6	15	М
		/Medic Examin		4a. Facility Name (If not inst.	itution, giv	e street and nu		J	4	lb. City, Town, o	or Location of De		40	. County of De	ath		
		ZX		Levindale H	ieal t	h Cent	ter			Ba 1	timore		1	Baltim	ore		
		Funeral		5. Social Security Number	6. 5	Sex		In yrs. last bi		If Under 1 Year Months Days			irth		nthplace (State or F	Foreign
		Director	Į.	212-18-9294		I□M 2 只 F	8	6	Yrs.	lonins Days	Tiodis	Sept.	9,19	919 N	aryl	and	
		pu ,	2	Usual Residence of Decede 10a. State 10b. Co			1	Oc. City, Tov	wn or Local	tion		- 1/2			10d In	side City	Limits
		aryla ehov	ž													Yes 2	
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		with a or	ū			7							_		Journay:		
		eath	Funeral Director	1700 Edmond	son	12. Was Dec	edent Ev	er in U.S.	13 Wa	21223	Hispanic Origin?	(Specify Yes or N		5 . A . 14. Race - An	erican Ind	ian.	
		ter d	Fun	1 Never Married 2	Married	Armed Fo	orces?	or w. o.o.	If Y	es, specify Cub	an, Mexican, Pu	(Specify Yes or N erto Rican, etc.)		Black, Wh	ite, etc.		
	336	al', or	by I	3√2 Widowed 4 □ Divo		1 □ Yes If Yes, Gi Year or □	veX ates:		1	Yes 2 No	Specify:			Specify: E	lack		
	5-0036	2 hou	ted	15. Dec	edent's E	ducation		16a	a. Deceden	nt's Usual Occup	pation during most of	watera	16b. K	ind of Busines	s/Industry		
	215	hin 7 9n "n	ple	Elementary/Secondary (0		ade completed) College (1-4or 5+)		life. DO	NOT use retire	id)	working					
	21	ad wit	Completed	8th					House	e Keep				otel			
	nd	al Hy al Hy d oth	Be	17. Father's Name (First, Mi	ddle, Last)						lame (First, Middle		n Surname)			
	yla	Ment Ment arkec	2	Charlie J	ohns	son					Maria	h Moore					
	Maryland 2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumetic event. It is Medical Evaria with intal be incliffed all QDGs.		19a. Informant's Name/Reia	ationship (Type, Print)		19	b. Mailing /	Address (Street	and Number or	Rural Route Numi	ber, City o	or Town, State	Zip Code,)	
	₹,			Wilbert Mod	re/l	Nephew		36	557 (Clifma	r Rđ	Windsor				124	4
	altimore,	of H If ite		20a. Method of Disposition 1 □xBurial 2 □ Crema	ation 3	Removal from	State	cemete	or Dispositi ery, cremai	ion (Name of tory or other pla	ce)	Date	20c. L	ocation - City o	r Iown, Si	ate	
	Ë.	ment ment:		14 ☐Donation 5 ☐ Oth	ner (Specia	fy)		Mt. 2				ril21,2	006	Balto	. MD		
	Ball	permit Depart Import any in		21. Signature of Funeral Se	rvice Lice	nsee	•		CA.	lame and Addre	ss of Facility SCRU	GGS FUN N ST. B	ERAI	HOME		_	
	_	0 □ = ≈ α		Cali	S									D. MD			
	Π.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Interv	oximate ral Betwe t and De	en ath
		Priysician	S v	Immediate Cause (Final disease or condition a. PANCREATIC CANCER													
		/Medical Examiner		resulting in death)		Due to	(or as a c	consequence	of):								
		_xammer		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):											-		
		ed sit	Examiner	Cause idisease or innuiv	~	Due to	(0) 43 4 6	consequence	01).								
	_	and and I-trar	хап	that initiated events resulting in death) Last		c. Due to	(or as a c	consequence	of):						-		
	8760,	ate be executed hysician and the burial-transit			- (`		,								
	687	ate the	Physician/Medical			d											
	Box (The law requires that the death certific tte has been signed by the attending p age 2 should be detached for use as!	M/S	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, ou								23d. Date of d	elivery		
	m	atter after I for u	clar	in the past 12 months'				Fetal deat ne of death		ctopic pregnanc other (specify) _	y .			Month	Day	Ye	ar
+	o.	that the de ed by the detached	ysi	9 Unknown		9□ Unkn	nown										
1	0	res that the igned by be detact		Part II. Other significant co	nditions	contributing to c	leath but i	not resulting	in the unde	erlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute	to the cau	se of dea	ith?
}_	ecords,	quires n sigr	d by									1 🗆	Yes 2	□No 3□	robably	4 JUni	known
الملا	00	w requir been si should	ompleted									24a. Wa		24b. Were	autopsy fin	dings av	ailable
3	Re	The la ate has page 2	Щ									perl	opsy formed?	death'			se of
-	Vital		Ö	25. Was case referred to m	edical						26 Place of I	1 ☐ Yes Death (Check only	2 X No	1 U Ye	s 2 0		
\cap		ysicien: is certific director,	To B	examiner? 1 □ Yes 2 No		Hospital:	Inpatient	2 ☐ ER/O	outpatient	3□ DOA Ot		gHome 5□Res		6 □Other (St	ecify)		
-	of	는 다 B		27. Manner of Death		28a. Date (Mor			Time of Injury	28c. Inju	ry at	28d. Describe					
To	Division	nding l ath. r: After e funer	ertification:		ending rvestigation		itii, Day 1	(Gai)	injury		Yes 2 □ No						
3	Vis	or Attend after death Director: , in by the f	ific		Could not be letermined	28e. Płace	e of Injury	/ - At home, f	arm, stree	t, factory, office		28f. Location City or To	(Street ar	nd Number or i	Rural Rout	Numbe	er,
RIGHI	ā		Cert	4 D Homodo		Julia	inig, etc.	(Opacity)				0.0, 0, 1,	Julia, Otale	-,			
3	7		edical									ace, and due to the				ause(s)	
Q	7	To the Hos within 24 h To the Fur completely	Medi	one)		and mar	nner state	d.									
	2	To To con	Σ	29b. Signature and title of c	eruner					29C. LICAN	se number	>	290. Da	ite signed (Mo	кп, ыау, Ү	car)	
	•			Alla /	Wills					P	1516		HA	7/17,	2006		
				30. Name and address of po	erson who	completed cau	se of dea	th (Item 23a)	(Type, Pri	int)	1.1 6	elvedes		Qie 1	211	1	1
				31. Date filed (Month, Day,	Year)	7/1/2/1	Registrar's	s Signature	1		W, D	elvedes	2 1	10-10	x-170.	1 1	1215
		Sta Registi		APR :		006	ALAST S	s Signature	Special services								_

			Please	Type or Prin					•	_			
		For State		State of Ma	arylan		artment of F		Mental Hygi	2000	2181		
		Registrar	ne (First, Middle, La	ct)			tillcate of	Dealii	2. Date of Death	g. No.	3. Time of Death		
Physici /Medic				William	s				April	Day Yea	00 10:0 A M		
Examin	er	4a. Facility Name &		e street and number)	~ n	1. 1.	4b. City, Town, o	r Location of Death	1	4c. County of Do			
		420	Deace			ircle	If Under 1 Year	If Under 24 Hrs.	UN		temore		
Funeral		5. Social Security N 214-50-		58 7. Ag		last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 8/17/19	Year)	Birthplace (State or Foreign Country)		
Director		Usual Residence o	0022	<u> </u>)				8/17/19	74/ 142	aryland		
2 should be the white 72 flous are lose if with the waysand and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-f show raumatic event, the Medical Examinar must be notified at		10a. State	10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits		
1	ģ	MD	Baltimo	re	Re	ister	stown				1 ☐ Yes 2 ☐ No		
or 28)ire	10e. Street and Nu					10f. Zip Code		10	g. Citizen of What	Country?		
23a	Funeral Director	423 Dea	acon Bro	ok Circl	e		21136			USA			
E E	nue	11. Marital Status		12. Was Decedent Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etç.		
0	by F	1 X Never Marr 3 Widowed	ried 2 Married	1 ☐ Yes 2 ☒ 1 If Yes, Give Year or Dates:	No		1 ☐ Yes 2 ◯XNo	Specify:		Specify:	African		
fura E	ed t	3 L 111001160	15. Decedent's E			16a Dece	dent's Usual Occup	nation	1	6b. Kind of Busine	merican ss/Industry		
e di	piet		cify only highest gra	ade completed)		(Give	kind of work done DO NOT use retired	during most of wor	king				
art T	Completed	Elementary/Seco	onuary (U-12)	College (1-4or 5	1+)	Nurs	e			State	ofMaryland		
othe ent,	Bec	17. Father's Name	(First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	aiden Sumame)			
Menta rked fice	ToE	Harrisc	n Tyler					Delois	McGloc	klin			
and is ma			lame/Relationship (ral Route Number,				
n 27		Arnetta	a Willia	ms/ Sist				Brook C			own,MD21136		
Department of Health and Ashida Hydene. Department of Health and Mental Hydene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28e-1 show injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Dis 1 ⊠ Burial 2	•	Removal from State	C	emetery, crer	sition <i>(Name of</i> matory or other plac			0c. Location - City			
ment tant: jury o	١.	4 Donation	5 ☐ Other (Special	(y)	Cr		wn Cem				sville, MD		
Depar impor eny in		21. Signatura Fi	uneral Service Lice	nsee	1								
70 7 4 0		21. Signature Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral HomePA of 9200 LibertyRd Randallstown, MD 21133 25. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
hysician and whisician and public and interpretation and the parial-transit	dical Examiner	Immediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Undo Cause (Disease or that initiated event resulting in death)	(Final on on on on on on on on on on on on on	a. Due to (or as c. Due to (or as d.	a consequ	Interval Batweer Onset and Death Conset and Death Conset and Death Conset and Death Conset and Cons							
within 24 hours after death. To the Funeral Director: Alter this certificete has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medic	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2: 9 ☐ Unknown	2 months?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3[□Ectopic pregnancy □ Other (specify) _	/		23d. Date of Month	delivery Day Year		
been signed by the s should be detached	by	Part II. Other signi	ificant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba		e to the cause of death? Probably 4 □Unknown		
ite has bee oage 2 sho	Completed								24a. Was an autopsy perform	ed? prior t	autopsy findings available to completion of cause of ?		
artific ctor,	Be	25. Was case refe examiner?	rred to medical					26. Place of Dea	th (Check only one)			
his ce I dire	2	1 □ Yes 2	140	Hospital: 1 Inpatie		ER/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	ome 5 Resider	nce 6 □Other (S	pecify)		
Alter t	on:	27. Manner of Dea 1 Matural	5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time o Injury	Wor	rk?	28d. Describe how	v injury occurred			
tor: / the f	cat	2 Accident	investigatio 6 □ Could not b	9	***			Yes 2 □ No	004 1 (04	4.66	2 12 14		
Direction of the control of the cont	Certification:	4 Homicide	determined	building, et			reet, factory, office		City or Town,		Rural Route Number,		
within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier (Check only one)	1 Certifying Pl	hysicien: To the best miner: On the basis o and manner st	f examina	włedge, deat tion and/or in	h occurred at the tir vestigation, in my o	me, date and place	, and due to the cai	use(s) and manner te and place, and c	as stated. due to the cause(s)		
within To the	Me	29b. Signature and Attle of certifier 29c. License number 29d. Date, signed (Month, Day, Year)											
1		20.11	MAC)	i i v	100	- 00a v T	Doing	10 ort	7	914	1006		
10		30. Name and add	ress of person who	completed cause of d	eath (Item	1 23a) (Type,	// AA	1.1.23	O DAUL	D HILL	ALLE DIDET		
Sta	ete.	31. Date filed (Mor	nth, Day, Year)	32, Registr	ar's Signa	iture	U IVI	J	100 /	- vinc	11 to well		
Registi		Л			A.	1	All s						
	-	H.	PR 1 8 200	D Jakov	A JAMES	1000							

				State of Maryland / Department of Health and M State of Maryland / Department of Health and M Certificate of Death	lental Hygien		2182
		Physici		1. Decedent's Name (First, Middle, Last) Wanda Louise Williams	2. Date of Death	7, 2006	3. Time of Death 7:30 A M
		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Toseph Richey Hospice Baltimore		c. County of Death	
		Funeral Director		5. Social Security Number 6. Sex 1 D M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea July 5, 1	r) + Coun	lace (State or Foreign try) Y.9 (and
		Maryland First m	tor	Usual Residence of Decedent 10a. State 10b. County N/A 10c. City, Town or Location Baltimore		1	0d. Inside City Limits 1 Yes 2 □ No
		death with the Maryland ms 23s or 28e-f show	Funeral Director	321 North Robinson Street 101. Zip Code 21224	l	Citizen of What Cour United	states
		irs after dea ii', or items xemiracini	by Funer	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forcas? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sprift Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B	
	21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Ind other than "natural", or items 23s or 28e-f show other than "natural", or items 23s or 28e-f show event, the Madical Examinat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) (ife. DO NOT use retired)	rina	Kind of Business/Ind	
130		ild be filed v fental Hygie rked other t tic event, III	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Maid CES Gr		
ut 7	, Maryland	es 1 and 2 should be f of Health and Mental F item 27 is marked of r other traumatic eve		19a. Informant's Name/Relationship (Type, Print) S'heila Williams - Daughter 321 North Robinson	Street E		MD. 21224
10%	altimore,	Page: nenf o ant: if			1006 -	Baltimere	, Maryland
4/13	Bal	permit. Departr Importe any inju		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Baltima	re, Margi	and 21229 Approximate Interval Between
		Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. —————————————————————————————————			Onset and Death
CXPITED	8760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transif	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hunur (all thumb) Due to (br as a consequence of): c. Due to (or as a consequence of): d.			
II. A.M.	O. Box 6	to death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of deliv Month	ery Day Year
111:	σ.	uires fhat the d signed by the id be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	
× 40	Records,	The law requir ate has been si page 2 should	Completed		24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to co	opsy findings available impletion of cause of
WANDA	n of Vital	To the Hospitel or Attending Physicien: The i within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	To Be	examiner? 1 Yes 2 X No	th (Check only one) ome 5 Residence 28d. Describe how in		mHOSPILL
-	Division	or Attendi after death Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St		al Route Number,
	Beerel	Ne Hospitel	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date and place of my knowledge, death occurred at the time, date of my knowledge, death occurred at the time, date of my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at the my knowledge, death occurred at th			
		To th withir To th	Me	29b. Signature and title of certifier 29c. License number 29c. License number D 003571	2	Date signed (Month, H/14/06	
_		4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Hamsin M.D. Regh Ridury Hospiu 828 N. Suku	wsr. Ba	16MD. 2	1201
	Sec.	St Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 8 2006 32 Registrar's Signature			

			1 - State Registrar	State of Maryland		rtment of H		lental Hygie	4000	12183
	Physici /Medic	State of the last	Decedent's Name (First, Middle, Last MARLENE		WH	IITMAN		2. Date of Death Month	Day Year	3. Time of Death
A CONTRACTOR OF THE PARTY OF TH	Examin Funeral Director	- 4	213 20 3170	ed of Balt		4b. City, Town, or 13 C 14 If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth APR. II,	4c. County of Dea	
	Maryland I-f ahow	tor	Usual Residence of Decedent 10a. State 10b. County MD BALT	10c, City	Town or Loc		·			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 28a	al Director	10e. Street and Number 2325 SUGARCONE RO	AD		10f. Zip Code	21209	10g.	Citizen of What C	ountry? USA
036	hours after deeth with the Maryland lural', or Itama 23a or 28a-f ahow at Extender must be modified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	within 72 ene. than "na!	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give)	ent's Usual Occupa kind of work done d O NOT use retired, IAKER	lurina most of work	ing 16t	OWN HOME	•
Maryland 2	be filed stal Hyg ad othe avent,	To Be C	17. Father's Name (First, Middle, Last) BENJAMIN		LUBAF	RSKY	18. Mother's Nam EDITH	e (First, Middle, Mai	den Sumame)	SCHUSTER
	1 and 2 sho Health and am 27 is m ther traums		19a. Informant's Name/Relationship (7) EDEE SCHNITZER / 20a. Method of Disposition	DAUGHTER 206. PI	10 MA	ARCIE WOO	DS COURT	al Route Number, C - BALTIM(Date 200		1208
Baltimore,	permit. Peges Department of I Important: If It any injury or o		1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Sign 1. 6 o Funeral Service Linen	removal from State	IE EMUN		CHAIM 4/1 s of Facility SOI	LEVINSON		, INC.
	Physician		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications hat caused the death ne cause on each line.				ROAD - PII or respiratory arrest,	KESVILLE,	MD 21208 Approximate Interval Between Onset and Death
58760, 本	Medical Examiner bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (o	ence of):	a scular cuno	Acc	dent		4 from 1 day 7 years
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Vital Records,		e Completed	Breast Car Basal cell 25. Was case referred to medical	carcin	umo	·	00 81	24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
ō	sing Phys n. After this funeral di	ToB	examiner? 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpatient 28b. Time of Inju ry	28c. Injury Work	or: 4 Nursing Ho	th Check only one ome 5 ☐ Residence 28d. Describe how		ecity)
Division	Hospitel or Attenc 44 hours after death Funerel Director: tely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,)			28f. Location (Stree City or Town, S	rate)	
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the comple	Medical	29a. Certifier (Check only one) 1 Certifying Phy one) 1 Certifying Phy one in the certifier	sician: To the best of my knov ner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	einion, death occur	red at the time, date	e(s) and mariner as and place, and due Date signed (Moni	e to the cause(s)
)	,}		30. Name and address of person and co	omplet reau of death (Item	M () 23a) (Type,,4	PA Print)	5 - 19	1627 A	ipril 1:	5.2006
	Sta Registi		31. Date fled (Month, Day, Y) ar)	D. Sinci Ho 32. Philistrar's Signati		of Ba	Himore	240/W	Belvede	no zizis

DHMH 17 Rev 1/2001

Whitman, Marlene

			1_ For State	State of N		d / Depa		t of H	ealth a	and M			2e() () 6	.	12184
			1. Decedent's Name (First, Middle, La	oct)		Cel	uncau	OIL	Jeani	-	2. Date of D	Reg. I	No.		2 Time of Death
П	Physici	ian									Month		. *	ear	3. Time of Death
	/Medi		Lorena S. Yo 4a. Facility Name (If not institution, given		ar)		4h City	Town or	Location of	of Dooth	April		6 . 20(4c. County of		4:30A
	Examir	ner								oi Death			- 1		
			Heritage Nurs 5. Social Security Number 6.5		Age (In yrs. la	st birthday)	If Under	unda 1 Year	3 ⊥ K If Under	24 Hrs.	8. Date of B	irth	Baltin	Birth	e (State or Foreign
	Funeral Director			1□M 2□XF		Yrs.	Months	Days	Hours	Min.	(Month, D	ay, Yea			place (State or Foreign ntry)
			Usual Residence of Decedent		82					A	pril	16	, 1924	W	V
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation			-				1	Od. Inside City Limits
	Mar Hied	tor	MD Baltim	ore	Di	ındal	le.								1 ☐ Yes 🏌 ☐ No
	r 28s	lrec	10e. Street and Number	or c		muar	10f. Zip	Code				10g. (Citizen of Wha	t Cour	ntry?
	h witi	ai D	7600 Meadow W.	av			213	222				7	USA		
	deat ms	ner	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S	i. 13.			spanic Ori	gin? (Spe	cify Yes or N Rican, etc.)		14. Race -		
9	after or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 27	No No	i	ires,spec 1⊡Yes 2				nican, etc.)		Black, \		
215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show ha Medisol Examirer must be notified at	d b	3	Year or Dates	s:		10163 2	XIVO	Specify:				Specify: W	hi	te
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121	lygie harti nt, th		8			Ass	istar	nt M	lana	ger			Retail		
ind	be fi	Be	17. Father's Name (First, Middle, Last)									en Sumame)		
7	i Mer Merke Parke	2	Roy Stewart								Grif				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treatments avent, the Medical Examiner must be notified at angle. Duce.		19a. Informant's Name/Relationship		1. 4								y or Town, Sta		,
	1 and Health em 27 thar tr		Charlotte Gleas	son-Daug							undal	_	MD 21		
Ö	ges T of F		20a. Method of Disposition 1 38urial 2 Cremation 3		10	ace of Dispo metery, cren			- 1				Location - Cit		
Baltimore,	permit. Pag Department Important: I any injury o		`4 ☐Donation 5 ☐ Other (Speci		Gar	dens	of I	ait	: h ! 4	4-18	-06_	Ros	edale	,	MD
3a	Deparition of the population o		21. Signature of Funeral Service Lice	nsee		22	. Name and	d Address	s of Facilit	^y Bra	dley-	Ash	ton F	une	eral Home
	20 = e a		THE THE			P	A, 21	. 34	Wil	Low	Sprin	g R	Rd., 2	122	2 2
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ŏ	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pre	ananav					23d. Date of	delive	ry
Ω.	the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	at time of dea		Other (spe						Month		Day Year
P.0	that the de ed by the detached	hys	9 Unknown	9∐ Unknown											
	ires tha signed d be de	by F	Part II. Other significant conditions	contributing to death	but not resul	ting in the ur	derlying ca	use give	n in Part I.		23e. Did	tobacco	o use contribut	te to th	e cause of death?
rd	w require been się should b										1 🗆	Yes	2□No 3□] Prob	ably 4 Onknown
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Ä	The lav	EO.									auto perfo	ormed?	deat	h?	npletion of cause of
Vital	sician: The certificate irector, pag	O	25. Was case referred to medical						26. Place	of Death	(Check only		40	103	ZIZ NO
\geq	S S II	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa	itient 2 E	R/Outpatien	3 DO	Othe					6 □Other (S	Specify	')
	ding Phy h. After thi funeral		27. Manny of Death	28a. Date of In (Month, L	njury Day Year)	28b. Time of	28	lc. Injury Work	-				jury occurred	, ,	,
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	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director:		29a. Certifier 1 Certifying Pl	nysician: To the bes niner: On the basis	st of my know	ledge, death	occurred a	t the time	e, date and	d place, a	nd due to the	cause	(s) and manne	r as st	ated.
	the H in 24 the F iplete	Medical	One)	and manner	stated.	on and or my	estigation,	пт тту орг	inion, deal	iii occurre	u at the time,	date a	nd place, and	aue to	the cause(s)
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			Samada	(1 11/1k	00	UD	, 1	ク2		08		4	117/	06	
	L)		30. Name and address of person who	completed cause of	f death (Item :	23a) (Type,	Print)	0	01		A	-1	-11		0:-
	ν/		Swinder (- Julle	, 2	Ma	Met	W.	r la	0	Deen	Su	ELL M	1/)	21222
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	Registr	rar	APR 1 8	2006	Esses A	K A	Back of								

DHMH 17 Rev 1/2001

ORIGINAL

			For - State Registrar	State of M	laryland / l	-	nent of H cate of L				ene 0 0 6)	12185
18		10	1. Decedent's Name (First, Middle, L	ast)					2	. Date of Death			3. Time of Death
70	Physici		Joseph	John		Zaj	of		7.	April 1	5, 2006 °	'ear	12:18 A M
	/Medio		4a. Facility Name (If not institution, g	ive street and number)	4b.	City, Town, or	Location		<u> </u>	4c. County of	Death	
2,600 - 600 - 400	<i>3</i>		Joseph Ritchie H	ospice]	Baltimo	ore			N/A	1	
A	Funeral Director		-		ge (In yrs. last bii 84		Inder 1 Year oths Days	If Under Hours	Min	Date of Birth (Month, Day, anuary 30	Year) 9 , 1922 Ma	Birthp Coun	
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aryla.	Show	_	10a. State 10b. County		10c. City, Tow	n or Location	1					11	0d. Inside City Limits 1 □ Yes 2 X No
ě.	P-98	Director	MAryland Balti	more	Dur	ndalk							
vith 1	Nor 2	Dir	10e. Street and Number			10	f. Zip Code	20		10	ng. Citizen of Wha	at Coun	try?
ath	a 230	rai	1627 Manor Road	10 Mas Danadas	- F in 11.0	10.144 - 5	2122		:-:-0 /0	()/ N-	USA	A /a	an India
ler de	He H	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceden Armed Forces 1 X Yes 2	?	If Yes	Decedent of Hi , specify Cuba	n, Mexica	n, Puerto Ri	can, etc.)	14. Race - Black,	White,	
)36 Irs af	i, or	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1110	1 🗆 Y	es 2🛚 No	Specify:	•		Specify:	Wh	ite
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Maryland 21215-0036	plene. r than "natural", or itema 23a or 28e-f show Lie Medical Exemanar must be politied at	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or	5+)	(Give kind o life. DO N	of work done o OT use retired	du <i>ring m</i> os f)	st of working				·
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uld b	nd Mental I marked o	10	Joseph Zapf					Ne	ellie	Mc Lau	ghlin		
aryi	C 00 =		19a. Informant's Name/Relationship	(Type, Print)	198	o. Mailing Ad	dress (Street a	and Numb	er or Rural F	Route Number,	City or Town, Sta	ate, Zip	Code)
	Health em 27 i		John Zapf	Sc				ad, E	Essex,		nd 21221		
ore	of Head if item or othe		20a. Method of Disposition 1 □ Burial 2 【▼Cremation 3	□Removal from State	remete	of Disposition ary, crematory	(Name of or other plac	e)	$\mathtt{Apri}^{\mathtt{Dat}}$	°17, 2	Oc. Location - Ci	ty or To	wn, State
Ë ª	ant:		4 □ Donation 5 □ Other (Spec		Bayvie	ew Cre	matory		2006		altimore	e Ci	ty, MD.
Baltimore,	Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Lic	ensee mm	Illy						undalk, undalk,		21222
	* 1		23a. Part1. Enter the disease, or co shock, or heart failure. Kist on	mplications that cause by one cause on each	ed the death.								Approximate Interval Between
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i §	the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of death	3 🗆 Oline	ar (specily)						
or E	ed by the detached	Q.	Part II. Other significant conditions	contributing to death	but not resulting i	in the underly	ing cause give	en in Part I	I.	23e. Did tob	acco use contribu	ute to th	e cause of death?
dS	ld be	d by								1 🗆 Ye	s 2 🗆 No 3 (☐ Proba	ably 4 Inknown
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The la	ate has page 2	щ								autopsy	ed? dea	ith?	osy findings available inpletion of cause of
	certificate rector, pag	ပိ	25. Was case referred to medical					OC Plan	o of Dooth III			Yes	2 No
		o B	examiner?	Hospital:	ient 2 ☐ ER/O≀	utnationt 2	DOA Othe	ac.		Check only one 5 ☐ Resider		(Ch-	Hospile
o g	erthis eraldi	$1 \vdash 1$	27. Manner of Death	28a. Date of Ini	ury 28b.	Time of	28c. Injury Work				w injury occurred	(Specify) Telpree
VISION Attending	r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, D	ay rear)	Injury M		Yes 2	No				
Division of l or Attending Phy	ector	E	3 Suicide 6 Could not determine	d 28e. Place of in	njury - At home, fa	arm, street, fa	actory, office		28	Location (Str. City or Town,	eet and Number	or Rurai	Route Number,
	s affe of Dir	Certification;	4 - Homoleo	building, e	itc. (Specify)					City of Town,	State)		
Hospitel	within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (29a. Certifier 1. Certifying I (Check only one)	Physicien: To the beseminer: On the basis and manners	of examination ar	e, death occu nd/or investig	urred at the tirr ation, in my op	ne, date ar pinion, dea	nd place, and ath occurred	d due to the ca at the time, da	use(s) and manne te and place, and	er as sta d due to	ated. the cause(s)
To the	within 2 To the complet	₹	29b. Signature and title of certifier				29c. License	e number		29	d. Date signed (A	Month, L	Day, Year)
) -	, F 0		Radiala		MI		7	000	576	44	4/1	4/1	16
	/1		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Type, Print)						1 10	
	9		Rachelleune	B2N Rmz	35 494	DSa	skn	Are	Be	44 1hm	ne 1	10	21224
6111	Sta		31. Date filed (Month, Day, Year)		trar's Signature	Sand!	P						
1	Registr	ar	APR 1 8 20	UD 1500 19.	1 55 /5	The state of the s							

			For State Registrar	State of Maryland		tment of H <i>ificate of L</i>		lental Hygie Reg	2000	12186
	Physici	20	1. Decedent's Name (First, Middle, Las	")				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic			ER Louis		ANDER		April	18 200	
	Examin	er	4a. Facility Name (If not institution, give	. 11		4b. City, Town, or	Location of Death	-05	4c. County of Dea	1 / -
-	Funeral		5. Social Security Number 6. Se	ORIAL HOSPI	birthday)	If Under 1 Year	4LTIM If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign
	Director		214-16-5241 11	DM 20 X F 85	Yrs.	Months Days	Hours Min.	JAN 16	1921 M	1ARYLAND
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c City T	own or Loca	ation		/		10d. Inside City Limits
	Maryla f eho	ō	MARILANA 1)	/A	01111	0	MORE	17	/	1∕QYes 2 □No
	1 the f	rect	10e. Street and Number	M	/	10f. Zip Code	MORE		. Citizen of What Co	ountry?
	death with the Maryland me 23a or 28e-f ehow frowet be codified at	aiD	2112 ALLEN	IDALE RO.	AD		21216	<i>'</i>	45,	4
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of Hi Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 ☐ Never Married 2 (★) Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑No If Yes, Give Year or Dates:	1[JYes 212 No	Specify:		Specify:	INAK
21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other then "natural", or iteme 23e or 28e-f ehow other then "natural", or iteme 23e or 28e-f ehow event, ite Madical Examiner must be calified at	ted	15. Decedent's Ed	ucation 1	6a. Decede	nt's Usual Occupa	ation	16	b. Kind of Business	/Industry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	nd of work done d O NOT use retired;	0			
	filed w Hygier kher th		10 THGRADE		DAY	CARE			SELF-	EMPLOYED
and	intal Hed of) Be	17. Father's Name (First, Middle, Last)	KIN	10		M A	e (First, Middle, Ma		NES
Maryland	should nd Me	ဥ	19a. Informant's Name/Felationship (7			Address (Street a	and Number or Rur	al Route Number, C		
ž	s 1 and 2 should f Health and Men Item 27 is marke other treumatic		DENISE JACK	SON (GRAND-DGT.)	2100	SOUTH	LAND K	D. BAL	TIMORE	4021207
ore	ges 1 and He it of He or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place	e of Disposi etery, crema	tion (Name of story or other place	9)	Date 20	c. Location - City or	Town, State
Baltimore	Part and Lary		4 ☐ Donation 5 ☐ Other (Specify	Woo		AWN (EN		24-06 0	DOODLAW	
Ball	permit. Departiments Import any inj		21. Signature of Fureral Service Liching	9. Bm	22.	Name and Addres	s of Facility BI		BALTOK	KAL HOME
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death. I one cause on each line.	Do not enter	the mode of dying	g, such as cardiac			Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	. CONGESTIV	E	HEART	TAILL	IRE		> NONTH
	/Medical Examiner		1	Due to (or as a consequen		RENTAL	Dic	THE		> LACATH
	<u></u> €.	ier	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	ce of):	7 675 15	10/20	CA &C		1
V	executed an and rial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Proumon	MA					< MONTH
Ő,	e exe sien ar urial-t	Ex	resulting in death) Last	Due to (or as a consequen	ice of):					< 1 1 100 574
68760	ificate be executed g physicien and as the burial-transit	edical	•	d. SEPSIS						1140119
Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy					23d. Date of de	livery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown		ctopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ned by the a detached f	Phy	9 Unknown					CO- Didaste		- d
Division of Vital Records,	w requires that the death cer s been signed by the attendin s should be detached for use	by	Part II. Other significant conditions of	ntributing to death but not resulting	ng in the unc	derlying cause give	en in Part I.			o the cause of death? robably 4 Unknown
3eco	e law has b	Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
al	ate pag		25. Was case referred to medical				00 Disease (Dasse	1 ☐ Yes 2 L		3 2□ No
Š	Physician: this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient 2 □ ER	/Outpatient	3□ DOA Othe	\r	ome 5 Residence	ce 6 □Other (Spe	ocify)
0	ng Ph fter th neral		27. Manper of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work		28d. Describe how		
sio	Attending ir death. ector; After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not be	<u> </u>		M 1 🗆 Y	res 2□No			
ΟĬ	tal or Attend is after death al Director; / ed in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, stree	et, factory, office		City or Town,	et and Number or R State)	urai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funaral director.	Medical	29a. Certifier 1 Certifying Phyone 2 Medical Exam	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, death of andror inve	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	withir Toth	2	29b. Signature and title of certifier	1.0 1		29c. License	number	290	Date signed (Mon	th, Day, Year)
			· Janyen	felovec, 1	リ	M72	4 28746	-F14 F	PRIC	18,20%
	10		DANIDELA	ompleted cause of death (Item 23	1,D.	rint) UNIE	N ME	HUPLAL	Hasp	THE MD
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9	32. Registrar's Signature	N. A	back				,

06-023	340
Addo.	Albert

Please Type or Print in Black Indelible Ink

o, Albert		1- For State Registrar	ite of Maryland	•	nent of cate of		Mental F		Reg. No. 20	06	1218
Physici dical Exami		Decedent's Name (First, Middle Albert	,Last)	Addo				2. Date of Dea Month April 5, 2	ath Dav Year		ne of Death
*		4a. Facility Name (if not institution 7108 Kirth Lane	, give street and numbe	r)	41	o. City, Town, or L LanHam	ocation of Deat	h	4c. County of Prince Ge	Death	
Funeral Director			5. Sex 7. A	ge (In yrs. last bi 51	rthday) Yrs.	If Under 1 Year Months Days			irth (MM/DD/YYYY) 24,1954	9 Birthplace Country) Afri	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locatio	יח	- T	+		10d. lr	nside City Lim
rland -f show once.	tor		e Georges	Lanh	am						Yes 2
the Mary 3a or 28a	Director	10e. Street and Number 9803 Goodluc	k Rd.			10f. Zip Code 207	06		10g. Citizen of Wha USA	t Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I file 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner, must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 X Mar 3 Widowed 4 Divo	12. Was Deceder Armed Forces 1 Yes rced If Yes, Give Year or Dates:		If Ye	Decedent of Hisps, specify Cuban, Yes 2 No	Mexican, Puerto		o- 14. Race - White,	American Ind etc. Blac	
hours a natura Examir	q pa	15. Decedent's Education (Speci	ify only highest grade co	durir		s Usual Occupation	on (Give kind of	work done	16b. Kind of Busi	ness/Industry	1
USD thin 72 ne. than "	nplet	Elementary/Secondary (0-12) 1 2	College (1-4 or			orking life. DO NO rvisor	OT use retired)		Aspen	Syste	ems
A1A13-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, L				1			Maiden Surname)		
Menta marke	ro Be	Alfred Ad 19a. Informant's Name/Relationshi		19	9b. Mailing	Address (Street		Danso	Da Imber, City or Town,	State, Zip Cr	ode)
Definition of the property of the popular of Health and Inportant: If item 27 is injury or other traumati		Angela addo/	Wife						am, MD 2		
ges l ar t of Hez I frite ther tr		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from S	State	atory or other		netery,	Date	20c. Location - C	ity or Town, S	State
iit. Pag irtment ortant: ry or o		4 Donation 5 Other Spe 21. Signature of Funeral Service L		Metr	opol	itan	of Facility 77	13/05	Alexand	lria V	/a
hysician		29a. Part I. Enter the disease, or of failure. List only one cause of	complications that cause	MOO /39 d the death. Do r						1D 206	
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensi Due to (or as a con		sclero	tic cardio	vascular (disease			Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a con	sequence of):							
T 15	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	sequence of):							
xecutes n and I - trans		X UNPENDED	d. AMENDED 1	itam#23a_2	7 nerMi	E,g856,6/12	2/06 TT				
ate be e	Medical	IF FEMALE:	23c. If yes, outco			1,g0.00,0/ 1 <i>a</i>	2/00 11		23d. Date of de	eliverv	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	1 Live birth 4 Pregnant a	at time of death	2 Feta	al death 3 [er (Specify)	Ectopic pregn	ancy	Month	Day	Year
es that the cigned by the detached	by Ph	Part II. Other significant condition	ons contributing to dea	ath but not resulting	ng in the ur	nderlying cause gi	iven in Part I.	23e. Did t	obacco use contribu	ute to the cau	ise of death?
quires t								1Ye		Probably 4	
The law rec ficate has be page 2 shou	Completed		7					24a. Was auto perfo 1 V Yes	psy pri prmed? de	ere autopsy fir or to completi ath? Yes	
sician: iis certi firector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 ER/0	Outpatient		of Death (Check Other ₄ Nursi		Residence 6	Other: Scene	•
Ital or Attending Physician: The law require its after death. al Director: After this certificate has been sigled in by the funeral director, page 2 should b	ation: To	27. Manner of Death 1 Natural 5 Pendi	2Ba. Date of In (Month, Day		Time of Inj	ury 28c. Injury	y at Work?	_	how injury occurred		
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:		not be 2Be. Place of I	Injury - At home,	farm, street	, factory, office bu	uilding, etc.	28f. Location (or Town,	(Street and N umber State)	or Rural Rou	ite Number, (
o the Hos ithin 24 ho o the Fun	Medical ((0.10011 0.11)	ysician: To the best of r niner:On the basis of ex and manner stated	amination and/or							∋(s)
F>F0	Š	29b. Signature and title of certifier				29c. License			29d. Date signed		y, Year)
3		30. Name and address of person v		. ,		O.C.N		24204	April 5, 2006		
9	tate		Assistant Medical 32. Registr			in Street, Balt	umore, MD 2	1201			
Regis			A.	as de	Spen	N.					
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DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** LEON HOWARD BARBOUR 12:50A APRIL 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FUTURECARE - SANDTOWN/WINCHESTER BALTIMORE CITYIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. 219-05-3102 Director 83 04/01/1923 VIRGINIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County ir than "natural", or Iteme 23a or 28e-f show the Medical Examinar must be notified at MD N/ABALTIMORE CITY 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 N. GILMORE STREET 21217 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BETHLEHEM STEEL Elementary/Secondary (0-12) College (1-4or 5+) PIPEFITTER CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN ROSIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3504 BERWYN AVENUE, BALTIMORE, MD 21207 f Health AIKO CAREY / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Depertment of H
Important; If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 4/24/06 CATONSVILLE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Altres /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the attending i IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by i Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ ackinsonism 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funarel Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number D 17537 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1600 W. MOUNT ROYAL AVE, BALTO MD 21217 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALUIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Amend Item 16b per F.H.G-854 4/19/06 reb Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year 8. 40 AM 2006 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and 4b. City, Town, or Location of Death Examiner 600d SAMaritay Baltimore Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, It's Madical Examiner must be notified at 1 Yes 2 □ No Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? or items 23a or Was Decedent Ever in U.S. Armed Forces?

1 Yes Yes Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🐪 Specify þ 3 Widowed "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than ndary (0-12) College (1-4or 5+) pervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth eny liquy or other traumatic event appra. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Prii Baltimore, Method of Disposition
Burial 2 Cremation 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Eur W. Kload such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) preumonia ration **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 0 9 Unknown Division of Vital Records, P. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? coronar 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Lase 2 No 1 ☐ Yes 2 ☐ No rs after deam.
ral Director: After this co.... 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after dea To the Funeral Directo completely filled in by th 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 000 4/18/2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 560; LOCHRAVEMBL., BALTIMORE, MD, 21239 sourdalnitski. Hogistrar's Signature 31. Date filed (Month, Day, Year) State 9 2006 Registrar

06-02559

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Steven Bridge 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 1325 hrs **Medical Examiner** April 15, 2006 Steven B. Bridge 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) **Baltimore County** Arbutus Avenue & Edmonson Ave. Catonsville If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Country) Maryland Director Sept.19,1944 219-42-7170 1X M 2 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Yes 2 X No 28a-f show Maryland Baltimore Catonsville 11: If item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g Citizen of What Country 10e. Street and Number 21228 USA 125 Forest Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 Never Married 2 X Married 2 X No Yes White f Yes, Give Year Yes 2 X No specify: Specify: 3 Widowed 4 Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours, nent of Health and Mental Hygiene ant: If item 27 is marked other th in "naturs 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Sales & Marketing Vice President 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Lipsitz Charles Bridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara O. Bridge Wife 125 Forest Avenue; Catonsville, Maryland 21228 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: Gardens of Faith 4/19/2006 Baltimore, Maryland Other Specif 10 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. permit. 1630 Edmondson Avenue; Catonsville, disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death a Sharp Force Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical physician at the burial -AMENDED UNPENDED Box 68760, IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Be of Vital Other₄ Hospital: 1 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 After this 1 🗸 Yes 27. Manner of Death 28a, Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject stabbed self Apr 15, 2006 1310 hrs Natural Division Yes 2 V No Pending death. Director: the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire 3 V Suicide Could not be or Town. State determined (Specify) In a car Arbutus Ave. & Edmonson Ave., Catonsville, Md. Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 16, 2006 O.C.M.E cun 30 Name and address of person who completed cause of death (Item 23a) 0 Assistant Medical Examiner Ling Li, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) APR 1 9 32 Registrar's Signature State 2006 Malers Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1 Decedent's Name (First Middle, Last) 2 Date of Death 3. Time of Death April 12, 2006 Year **Physician** 8:20РМ м Charles Bernard Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's 9405 Hale Drive Clinton If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, October 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** $12^{(4)}, 1950$ Months Days North Carolina **1**XXM 2□ F Yrs. 239-84-4190 55 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturel", or iteme 23s or 28s-1 show other traumatic event, the Medical Exact material respectively. 1 ☐ Yes 2√☐ No Maryland Prince George's Clinton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 U.S.A. 9405 Hale Drive Completed by Funeral 12. Was Decedent Ever in U.S. Ammed Forces? ₩XYes 2□NoVietnam If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filled within 72 hours after of the filled and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry
U.S. Government 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Office 12th Group Chief 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pledger Charles Brown Qunnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Brown(Wife) 9405 Hale Drive Clitnon, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) April 19, 20a. Method of Disposition 20c. Location - City or Town, State Department of the important: if its any injury or of once. 1 Burial 2 Cremition 3 Removal from State Maryland Veterans Ceml Cheltenham, Maryland 4 Donation 5/ Other (Specify) 2006 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signal re of Frine al Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20735 mo 1461 9,11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerosois disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Hyperlipidemia 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: : After this certifice e tuneral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 NResidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2√ No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funaral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 18 OFI. 106 H0060781 182 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 6104 Old Branch Avenue Temple Hills, MD 20748 Nicole Richardson, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

			1 - For State Registrar	State of Ma	aryland / I	-	rtment tificate			and M	ental Hy	giene Reg. No	UUT)	1219	12
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Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Department of Health end Mental Hygiene importent: if item 27 is marked other then "naturat", or iteme 23a or 28e-f show eny injury or other treumatic event. The Madical Examiner must be notified at once.		21. Signature of Funeral Service Lice	nsee			Name and			1940	Home		050 Y owson		Road 21204	loc.
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	To th within To th	Me	29b. Signature and title of certifier	6			29c.	License	number			29d. Da	ate signed		Day, Year)	
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,	nT		30. Name and address of person who	completed cause of c	leath (Item 23a)	(Туре,	Print)					7				
/	d		LILIA CEBALLOS				DRI	VE	TOWS	ON	MARYLI	AND	2120	14		
4.	Sta Regist		31. Date filed (Month, Day, Year) APR 1 9 2	32 Registr	rar's Signature	Light	we									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 04716/2006 12:40 p M Charles Bock, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 608 Nicoll Ave. Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 191-18-4633 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**火**□M 2□F 82 Oct. 27,1923 Penn Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 No N/A Baltimore City Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Nicoll Avenue 21212 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yr's Machinist Machine Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Huber Bock Armatha Cashman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21212 608 Nicoll Avenue Charles M. Bock, Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 19, 2006 Baltimore, MD Gardens of Faith 22. Name and Address of Facility Baltimore, Maryland 21214 21. Signature of Funeral Service License 1200/2 Inc. 5305 Harford Rd. Leonard J. Ruck. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PACAJE, with Metastases CANCER OF 2 months TOBACCO Sequentially list conditions, Dualto (or as a consequence of): Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last AZCO HUL Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed the ettending physicien 68760 Box o been signed by Division of Vital Records, has this certificate To the Hospitel or Attendi within 24 hours effer death. To the Funeral Director: completely filled in by the Medical

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Marital Examiner must be notified at a date.

Priysician

/Medical Examiner

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) APR 1 9 2006

DAVID

29b. Signature and title of certifier David &

> 7505 OSLER DR #510 BOERSMA 32. Registrar's Signature Carl Some

recorne mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWSON MD

29d. Date signed (Month, Day, Year)

29c. License number

D40048

Please Type or Print in Black Indelible Ink
of Maryland / Department of Health and Mental Hygiene

Patricia Buckinghai		Sta For State	ate of Mary		partment ertificate			Menta	al Hy			20	00	1010
Physician/	R	egistrar . Decedent's Name (First, Middl	e,Last)		ertineate	- Dear				2. Date of De		6 U	$\frac{U}{3}$. Time of Death
Medical Examine	r	Patricia	Dorothy	Bucki	ngham	Tab City	Town, or L	contrar of	Doeth	Month April 16,		Year County of	Doeth	1312 hrs
	4	a. Facility Name (if not institutio 4620 Harcourt Road	n, give street and	number)		Balti		ocation of	Death		40.		I/A	
Funeral	Ę	5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Und	ler 1 Year	If Under	24Hrs.	8. Date of E	Birth(MM/D	D/YYYY)	9. Birth	place (State or
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5-0036 led within 72 hour Hygiene. other than "natu the Medical Exar Completed			5-	+		Teac							e C	o. Schools
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 17 is market other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		17. Father's Name (First, Middle,		Cu			11	8.Mother's Ida		First, Middle	, Maiden S Hol			
21215-C 21215-C Mental Hygi marked oth, ite is event, the i		Thomas Patr 19a. Informant's Name/Relations	hip (Type, Print)	yes, Sr	19b. Ma	ling Addres	s (Street			ural Route N			State, 2	Zip Code)
MD d 2 sho lith and n 27 is aumatie	1	Mr. Thomas P. I	Hayes, J	r./Brothe	er 6	Burl	Court	: Ba	ltim	ore, N	-		212	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after dement of Health and Mental Hygiene. Intel. Titem 27 is marked other than "natural", or or other traumatic event, the Medical Examiner margor or other traumatic event, the Medical Examiner margor or other traumatic event, the Medical Examiner margor other traumatic event, the Medical Examiner margor of the Completed by Fu		20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Remova		Ob. Place of Dis crematory o			etery,		Date	- 1	ocation - C		
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Baltimore, permit. Pages I an Department of Hea Important: If ites injury or other tr		21. Signature Huneral Service	Mich	naet E. Ca	anapp 2	Name an			ı T	nc 5	305 Ha	rford	Rd	Balto. 21214
Physician	-	23a. Part I. Enter the disease, or		at caused the de	eath. Do not ent									Approximate Interval
/Medical	1	failure. List only one cause Immediate Cause (Final disease		iomegaly v	with bive	ntricu	lar di	lation						Between Onset and Death
Examiner		or condition resulting in death)		is a consequence										
3		Sequentially list conditions, if any, leading to immediate	b. Due to (or ε	s a consequenc	ce of):								-	
ed nsit		cause. Enter Underlying Cause (Disease or injury that initiated	С.											
		events resulting in death) Last	d Due to (or a	as a consequent	ce of):									
ial al	2 -	X UNPENDED	AMENDE	D Item#	23a,27,p	erME,g	354,4/2	25/06	TT					
Box 68760, a death certificate be the attending physicing for use as the burn extra conficient Medician/Medicia		IF FEMALE: 3b. Was decedent pregnant in t	ho —	es, outcome of p	pregnancy		- [Date of d		
Box 6876(The death certificate of the attending physical for use as the box of for use as the box of for its and the state of the stat		past 12 months?	I L LIV	/e birth egnant at time o	2 of death 5	Fetal deatl Other (Sp	_	Ectopic	pregnar	ncy		Month	Da	y Year
). Boy the death by the attended for a physical	DISECT OF THE PROPERTY OF THE			nknown										
that the sed by detach	y T	Part II. Other significant condi	tions contributin	ig to death but n	not resulting in t	ne underlyir	ng cause gi	iven in Par	rt I.	23e. Did			_	e cause of death?
IS, P.C quires that en signed let a let be deta	led l									24a Wa		-		psy findings available
cords, law require has been so a should	Сотріете									aut	opsy formed?	pri		mpletion of cause of
tal Rection: The I certificate I ector, page		25. Was case referred to medica			_		26 Place	of Death (Chook	1 Yes	s 2 No	1 •	✓ Yes	2 No
Vital hysiciau: this certifi I director,	e o	examiner?	Hospital: 1	Inpatient 2	ER/Outpat	ient 3		Other ₄		Home 5	Reside	nce 6 🗸	Other:	Scene
Division of Vital Records, tal or Attending Physician: The law require as after death all Directors. After this certificate has been siled in by the funeral director, page 2 should be destribed. To Be Commission	- 1	27. Manner of Death	28a. D	ate of Injury onth, Day, Year)	28b. Time	of In jury	28c. Injur	y at Work	7	28d. Describ	e how inju	ry occurred	1	
ion itendii leath tor: A	Certification:		ding estigation				1 Y	'es 2	No					
ivis lor Ar after of Direc	<u> </u>	3 Suicide 6 Cou	ild not be 28e F	Place of Injury - A	At home, farm,	street, facto	ry, office bu	uilding, etc	,	28f. Location or Town		nd Number	or Rura	I Route Number, City
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the		4 Homicide	1 (0,000		uladaa daath a		aa tima da	to and nin	00 000	dua ta tha na		d mannar a	a atarta	A
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Directors. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bodies of Cornelled of the Divisional Machine and Contribution. To Be Commissed the Divisional Machine and Contribution and Contribution and Contribution and Contribution.	Medical	(Check only one) 2 Medical Exa	Physician: To the aminer: On the ba	sis of examination										
7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ĕ	29b. Signature and title of certifi	er and mann			2	9c. License	number			29d [Date signed	(Mont	h, Day, Year)
		aue 57	`	MO			O.C.N	M.E.			Apri	17, 200)6	
0	1	30. Name and address of person				n Street	Raltima	re MD	21201					
<i>D</i> Stat	to	Ana Rubio MD. As 31. Date filed (Month, Day, Year,	sistant Medic	al Examiner . Registrar's Sig		n Sueet,	Daiti1110	TE, IVID	£ 120 l					
Registra		APR 1 9	2006	188018 2 M	St. San	all a								

			1 = For State Registrar	State of Maryla	•		nt of Healt te of Dea			gieņe Reg. No. 0 0 6	12195
. D	* ± y	. <u>%</u>	1. Decedent's Name (First, Middle, Last	t)	. –				2. Date of Dea		3. Time of Death
	Physici /Medic		Timo	thy Michael E	renner					15, 2006	12:40P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, or Locat	ion of Death	ı	4c. County of i	Death
			67 Vista Mobile				undalk				more Co.
	Funeral		5. Social Security Number 6. Se 212-56-8952	DIM 2018	. last birthday) Yrs.	Months		nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	h y, Year) 9.	Birthplace (State or Foreign Country)
. '	Director		Usual Residence of Decedent	54	115.				July 1	,1951	Maryland
	and		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Mary -1 sh	ğ	Maryland	Baltimore			D	undal	k		1 ☐ Yes 2 ☐No
	1 the	Directo	10e. Street and Number			10f. Z	p Code			10g. Citizen of Wha	t Country?
	3a o	O E	67 Vista Mobile	Drive			212	22		United S	States
	death	Funerai	11. Marital Status	12. Was Decedent Ever in Armed Forces?	J.S. 13.	Was Dece	dent of Hispanio	Origin? (Sp	pecify Yes or No o Rican, etc.)	14. Race -	American Indian, White, etc.
9	or its	F.	1 ☐ Never Married 2 ☑ Married	1 XYes 2 ☐ No If Yes, Give			2\lambda No Spe			Specify:	Willia, olc.
200	ural',	d by	3 Widowed 4 Divorced	Year or Dates:							White
2	be filed within 72 hours after death with the Maryland at Hydiene. I at Hydiene. I other than "natural", or items 23a or 28a-f show event, the Macilial Examinar must be motified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usu	al Occupation ork done during ise retired)	most of wor	king	16b. Kind of Busin	,
21215-0036	withir ane. then	d L	Elementary/Secondary (0-12)	Coltege (1-4or 5+)					100	National Graphics	
2 2	Hygie ther ant,	ပိ	12 Years 17. Father's Name (First, Middle, Last)		Su	pervi		lother's Nam	ne (First, Middle,	Maiden Sumame)	<u> </u>
_	0 = 0 5	To Be	Calvin Brenner					Dor	othy Cof	fman	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than " reumatic event, the Me	F	19a. Informant's Name/Relationship (T	Type, Print)	19b. Maili	ng Addres	s (Street and Nu			or, City or Town, Sta	te, Zip Code)
Š	nd 2 allth a 27 ls r treu		Sandra J. Brenne	er	67 7	Vista	Mobile	Dr.	Baltimor	e, Maryla	and 21222
ō,	f Hei frem frem othe		20a. Method of Disposition		Place of Dispo	osition (Na matory or	me of other place)		Date	20c. Location - Cit	y or Town, State
Ë	Page nent c int: If iry or		1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		illtop	Serv	ice Cor	p. 4/	19/2006	Towson,	Maryland
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is merked any Injury or other treumatic et <u>pnce</u> .		21. Signature of Funeral Service Licens	S00	2	2. Name a	nd Address of F	acility		n 3.31	-
m	22 5 2		-2000 C	∠ .	D	uda-1 7922	wck Fun Wise Av	e. Du	nome or indalk,	Dundalk, Maryland	Inc. 21222
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea one cause on each line.	ath. Do not en	ter the mo	de of dying, suc	h as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Pnysician	0	Immediate Cause (Final disease or condition	. END STAGE	E LIVE	-R	DISEASE	5			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	The second section is a second						
38	Examiner		Sequentially list conditions,	b							
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760,	certificate be executed ding physicien and ise as the burial-transit	ical									
687	ficate physics the	edic		d							
Box		Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		7				23d. Date o	f delivery
m	0 0	cia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fe 4 Pregnant at time of		_Ectopic _Other (s				Month	Day Year
о. О	t the by th tache	hys	9 🗆 Unknown	9[] Unknown							
	as the	by P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the u	inderlying	cause given in F	Part I.		./	te to the cause of death?
Records,	w require been sig should t								101	/es 2. 1 No 3[Probably 4 Unknown
ပို	e law r has be ge 2 sh	pie							24a. Was	osv prio	e autopsy findings available r to completion of cause of
		Completed							perfo	rmed? dea 2. No 1 □	th? Yes 2□ No
/ita	ysicien: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	Elogoitali					th (Check only o		
5	Physi this o	၉	I Yes 21/2 No		ER/Outpatie		OA Coner: 4[Nursing H		dence 6 Other (Specify)
ב	ding f h. After funer	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes	2 □No	280. Describe i	now injury occurred	
<u>s</u>		icat	2 Accident investigation 3 Suicide 6 Could not be		home farm st			2 []110	28f Location (Street and Number of	or Rural Route Number,
Division of Vital		Certification:	4 ☐ Homicide determined	building, etc. (Spec			, J. 511100		City or Tox		
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	aic	29a. Certifier 1 Certifying Ph	y sicien : To the best of my kr	nowledge, dea	th occurre	d at the time, da	te and place	, and due to the	cause(s) and manne	er as stated.
	P Fu	edical	(Check only 2 Medical Examone)	niner: On the basis of examinand manner stated.	nation and/or in	nvestigatio	n, in my opinion.	death occu	rred at the time,	date and place, and	due to the cause(s)
	To the within 2 To the Complet	ž	29b. Signature and title of certifier				c. License num			29d. Date signed (A	
			america	ne Mo			D160	19		April 1	8, 2006
h	, 19	†	30. Name and address of person who	completed cause of death (Ite	эт 23а) (Туре	, Print)	1.	7.22		010-1-	8, 2006 DE, MO. 21236
2	111		C.VERGARA-S			AUKL	IN SG	WARE	DIZ.	DALIIMOR	E, MO. 21236
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sign		Cons	843				

Almaz Bekele more, Maryland 21215-0036

		Amend ite 1- State Registrar	Please em#15,19a,p	Type or Pri erH, 8855, 5, State of M		Indelible Ink partment of ertificate of			Are Legible.	12196
Physici /Medic Examir Funeral	cal	ALMAZ 1 4a. Facility Name (h DOCTORS 0 5. Social Security N	BEKELE If not institution, give COMMUNITY lumber 6. S	street and number)	ge (In yrs. last birthd	LANHAM If Under 1 Year Months Days	If Under 24 Hrs.	2. Date of Dea Month	th Day Year 15, 2006 4c. County of Dea PRINCE GE	
Director 8a-f show	Director	214-37-18 Usual Residence of 10a. State MARYLAND	Decedent 10b. County PRINCE G		39 Yrs 10c. City, Town or BOWIE	Location		12/19/19	966 ETI	10d. Inside City Limits 12 X es 2 □ No
Ind 21215-0036 be filed within 72 hours after death with the Maryland tal Hygiene. to other than "natural", or Items 23s or 28s-f show event, the Modical Exercited must be invitilised at	Funeral	_	ERCREST	12. Was Decedent Armed Forces 1	Ever in U.S. 1	10f. Zip Code 207 3. Was Decedent of If Yes, specify Cut 1 □ Yes 2X No	Hispanic Origin? (Spoan, Mexican, Puerto		U.S.A. 14. Race - Am Black, Whi Specify: BLA	erican Indian, te, etc.
2121 ad within rgiene.	Completed by	Elementary/Seco	15. Decedent's Ecify only highest gra		5+) (G	cedent's Usual Occu ive kind of work done b. DO NOT use retire DATA ENTRY	during most of work ad)		16b. Kind of Business	/Industry
Maryla	To Be	BEKELE WO	(First, Middle, Last) ORDOFA ame/Relationship (7) AKONNEN —				BIRTUKAN	DEMESA	r, City or Town, State,	Zip Code)
Baltimore, permit. Pages 1 an Department of Heat Important: If Itam 2 any injury or other once.		4 Donation	position Cremation 3 5 Other (Specify Ingral Service Licenters)		20b. Place of Dicemetery, of	sposition (Name of trematory or other pla COLN CEMET 22. Name and Addr	ERY 4/19	/06 E T LINCOL	20c. Location - City of BRENTWOOD, IN FUNERAL WOOD, MARY	MARYLAND HOME
Physician /Medical		23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	irtfa¶lure. Listonty⊹ (Final	ofications that cause one cause on each I	d the death. Do not ine.	enter the mode of dy		or respiratory arr		Approximate Interval Between Onset and Death
rificate be executed my map physicien and as the burial-transit	Ical Examiner	Sequentially list contrains, feating to incause. Enter Unde Cause (Disease or that initiated events resulting in death) to	orlying injury	с.	a consequence of):		10 10 100 100			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 25 9 Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	y		23d. Date of de Month	livery Day Year
Cords, P.	þ	Part II. Other signif	ficant conditions o	ontributing to death t	out not resulting in th	e underlying cause g	ven in Part I.	1 🗆 Y		robably 4 Dunknown
Vital Records, sician: The law requires t certificate has been signe lirector, page 2 should be or	o Be Completed	25. Was case reference examiner?	,	Hospital:	a DE RIO	00	26. Place of Deat	h (Check only on	y prior to death? 2☑ No 1 □ Yes	
Division of all or Attending Physical or Attendenth. Director: After this din by the funeral di	Certification; To	27. Manner of Death 1 2 Natural 2 Accident 3 Suicide 4 Homicide		28e. Place of In	ury Year) 28b. Time Injury	e of 28c. Injury Wo	ry at sirk? Yes 2 No	28d. Describe ho	ence 6 Other (Spectrum) Owninjury occurred Preet and Number or R	
DIVIS To the Hospital or Attuwithin 24 hours after defined To the Funeral Directo completely filled in by the	Medical Cert	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	vsicien: To the best	of examination and/or	eath occurred at the t investigation, in my	me, date and place, opinion, death occur	City or Town and due to the cred at the time, d	ause(s) and manner a ate and place, and du	s stated. s to the cause(s)
To the comp	Me		me E	Pollers.	MA) death (Item 23a) (Typ	mDi		3	9d. Date signed (Month	2006
Sta Registr	ar	James E	POlloc.	K 575	- Main St	Suite	351 Lai	urel, n	1D 2070;	7

06-02517

Briana Leigh Boone

Please Type or Print in Black Indelible Ink

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State of Maryland / De	partment of Health and Mental Hygiene

	R	- For State egistrar				Certif	icate o	f Death			R	eg. No. 9 ()	no	10	LOI
Physician/ Medical Examine	1	. Decedent's Name									Date of Dea Month April 13, 2	Day Yea	. U3. г	Time of De	eath 🥒 .
Wedical Examine		B la. Facility Name (i	<u>riana</u> f not institutio	Leig on, give street an	n Boc d number)	ne	1	4b. City, Town,	or Location		April 13, 2	4c. County o			
		Fort Washir						Fort Wash				Prince G			
Funeral Director		5. Social Security N		6. Sex		In yrs. last	birthday) Yr:		ys Hours			th(MM/DD/YYYY) 2/2006			or yland
yland -f show any once. :tor	1		10b. County Princ	e Geor	ges 1	oc City, To Fort	wn or Loca Was	hingto	n 				1		City Limits
th the Maryland 23a or 28a-f show notified at once.		386 Ind						10f. Zip Code 2074				0g. Citizen of Wh			
s after death wi rral", or items niner must be by Funers	<u>-</u>	1. Marital Status 1. X Never Marrie 3. Widowed 15. Decedent's Ed	4 Div	arried Arme 1 Yorced If Yes, Give or Dates:	Year	ζ No	1f \ 1	as Decedent of the second of t	an, Mexican Io specify:	n, Puerto Ri	ican, etc.)	14, Race White Specify:	Bla	ck	ack,
5-0036 ed within 72 hour lygiene. other than "naturalle Medical Exan Completed	-	Elementary/Seco			ge (1-4 or 5+		during n	nost of working li					I/A		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Comple	3	17. Father's Name Lee Boo	ne						Sha	wn :	Boone	Maiden Surname)			
ages 1 and 2 should nt of Health and Me it. If item 27 is ma other traumartie ev	L	19a. Informant's Na Lee & S 20a. Method of Dis	hawn			nts	8386		n He			pt B1 F	T.Wa	sh. 744	MD
Baltimore, bernit Pages I ar Department of Hee Important: If ite		1 Burial 2 4 Donation 5	X Cremation	n 3 Remov	al from State	Res	matory or or oppolit	ther place) CCION an		4/18/ 4/2	72006 4 / 0 6 	20c Location - Alexandr - Clint	on,	MD	
	ł	21. Sign, ture of L 22. C 23a. Part I, Enter th	2500	411	MA (3 48	20	Name and Addre	uasc	o Rd	. Aqu	neral H asco, M	1D 20	PA 0608 Approximat	te Interval
Physician /Medical xaminer	4	failure. List on Immediate Cause (or condition resulti	nly one cause (Final disease	e on each line. a. Sudde		nt Deat		rame (SID		Salulac of 1	espiratory arr	est, shook, or nee		Between C Dea	Inset and
		Sequentially list co if any, leading to in cause. Enter Union	nmediate		as a conseq	uence of):									
3760, ificate be executed g physician and s the burial - transit	Exalli	(Disease or injury to events resulting in	that initiated	C.	as a conseq	uence of):									
e execucian and rital - tra	<u> </u>	X UNPENDED)		ED item	# 5 , 201	o-c,per	FH,G854,4	/19/06	TT it	em#23a,2	27, perME, g8	356,6/2	20/06 :	TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit policy of effication: To Be Completed by Directing Information Expension.		IF FEMALE: 3b. Was decedent past 12 months 1 Yes 2	s?	he 1 L	ves, outcome ive birth regnant at til		2 F	etal death (B Ectopi	ic pregnanc	су	23d Date of Month	delivery Day	,	Year
P.O. Es that the estrated by the estrached	2	Part II. Other sign	ificant condi	tions contributi	ng to death I	but not resu	ıltıng in the	underlying caus	e given in P	art I.		obacco use contri			
Division of Vital Records, P.O. Box 68 Within 24 hours after death cert within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death cert rothe Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a conficual Certification: To Be Completed by Physicial	najaidillo										24a. Was autop perfo 1 V Yes	psy prmed? d	Vere autoportion to compleath?		
ician: T	υl	25. Was case referexaminer?	rred to medica	Hospital:			2/0-4		Other			Davidson C	704		
on of Vi ending Physi arth. or: After this the funeral di		1 ✓ Yes 27. Manner of Dea 1 X Natural	5 Pen	28a. I	Date of Injury Month, Day,Yea	t 2 🗸 EF	8b. Time of	Injury 28c. Ir	Yes 2	k? 2	Home 5	Residence 6 how injury occurre	Other:		
Division Septial or Attend hours after death. Ineral Director: y filled in by the foothing the	Certification	2 Accident 3 Suicide 4 Homicide	6 Cou	estigation 28e. Ild not be ermined (Spe		iry - At hom	e, farm, stre	eet, factory, office	e building, e	etc. 2	8f. Location (or Town, §	Street and Number State)	er or Rural I	Route Nun	nber, City
To the Hosp within 24 ho completely formal confined of the formal confined of the formal form	<u></u>	29a Certifier (Check only one) 2	-	aminer: On the b	_	_						se(s) and manner and place, and d			
		29b. Signature and	all	02/1	61				nse number C.M.E.	r		29d. Date signed April 13, 20		Day, Year,)
		30 Name and add Zabiullah A	li, M.D.	Assistant Me	edical Exa	aminer	111 Pe	nn Street, Ba	altimore,	MD 212	01				
Stat Registra	••	31. Date filed (Mor	APR	, 1 9 2006	2. Registrar's	s orginature	M.	South	4.						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and I State of Maryland / Department of Health and I Certificate of Death	•	giene 006	12198
34		N -	Decedent's Name (First, Middle, Last)	2. Date of De		3. Time of Death
	Physici /Medi		Raymond Augustus Burch, Jr.	APRIL	10 2006	8:02am M
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat CIVISTA MEDICAL CENTER LA PLATA	n	4c. County of Deat	n
No.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			hplace (State or Foreign untry)
j.	Director		578-40-4619 TSM 2 F 74 Yrs. Months Days Hours Mill.			aryland
	ryland how Lat		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Ma	ecto	MD Prince Georges Upper Marlboro			12 Yes 2 No
	th with the	al Dir	10e. Street and Number 10900 Old IndianHead Rd. 20772		10g. Citizen of What Co USA	untry?
1/ch	s 1 and 2 should be tiled within 72 hours atter death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itema 23a or 28a-f ehow other traumatic event, the Medical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerl If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl II) Yes, Sive Year or Dates:		14. Race - Ame Black, Whit Specify: B1	e, etc.
215-15	within 72 h ene. than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	rking	16b. Kind of Business/	Industry
213	tiled witl Hygiene sther the		12 Truck Driver	(T)	Self Empl	loyed
and	id be til ental H ked ott	To Be	17. Father's Name (First, Middle, Last) Raymond A. Burch, Sr. Mary H		, Maiden Sumame)	
MON larylan	2 should and Men is marke	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Numb	er, City or Town, State, 2	Ep CodMD20772
7. ≥.×.	1 and 1 Health em 27		Leisha Singleton/Daughter 10900 Old Indian 20a. Method of Disposition 20b. Place of Disposition (Name of	Head R	d. Upper A	
No.	ages ant of h it: if lite y or of		Maryland Veterans 4/20 Maryland Veterans 4/20		Cheltenha	
A Hymon () Baltimore, Maryland	permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than any injury or other traumatic event, ILLE MA. 2010e.		21. Signature of Ednaral Service Licensee) 22. Name and Address of Facility A	dams F	uneral Hor	ne, PA
	40540		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate
	Physician		Immediate Cause (Final disease or condition		2	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	/D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
A.	ificate be executed g physicien and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c			
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	artificat ing phy e as th		IF FEMALE:			
P.O. Box	law requires that the death certifi: as been signed by the attending ! 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of del Month	very Day Year
	uires that signed to ld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CEREBROY AS CULAR ACC. DENT		obacco use contribute to Yes 2 No 3 Pr	
900	aw requir is been si 2 should	Completed	PROSTATE CANCER	24a. Was	an 24b. Were au	topsy findings available
E R	The ste h	Com		perfo	rmed? death?	
Vita	Physician: The this certiticate har director, page	Be c	examiner?	ath (Check only o		
Division of Vital Records,	ding Ph J. Atter th tuneral	tion: To	1 Yes 2 No Hospital: 1 Impatient 2 EFVOutpatient 3 DOA Other: 4 Nursing F 27. Manner of Death	T	dence 6 Other (Spec how injury occurred	city)
Divisi	l or Attendi atter death. Director: A	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or Ton	Street and Number or Ru wn, State)	ral Route Number,
_	To the Hospitel or Attent within 24 hours after death To the Funarel Director: completely tilled in by the	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Monti	n, Day, Year)
			D-44436		April 10	2000
	3		30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) ASHVIN J. PATEL MD 102 PAUL MELLON COURT WALDORF MAR		,	*
	Sta Registi	ate rar	31. Date filed (Month, Day, Year) 32 degistrar's Signature			

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene Jacqueline Lavern Borrell

		I- For State Registrar	Certific	cate of Dea	itn	Re	eg. No.	100 1213
Physicia	ın/	Decedent's Name (First, Middle,Last)				Date of Deal Month	Day Yea	3 Time of Death
al Examir		Jacqueline Lavern Bo		145 035	Town and another of	April 17, 2	006	0619 nrs
		4a Facility Name (if not institution, give street and number Rt. 97 @ Stone Road	er)		Town, or Location of stminster	Death	4c. County of	or Death
Euporol			Age (In yrs. last bi		der 1 Year If Under	24Hrs 8 Date of Bir	th(MM/DD/YYYY	9. Birthplace (State or
Funeral Director			69	Mon	ths Days Hours	Min	· ·	Foreign collegyth Carol
	- 1	215-32-7009 1 M 2 XF Usual Residence of Decedent	07	Yrs.		oan.	7,1937	COLUMN OLL COL
any	ŀ	10a. State 10b. County	10c. City, Town	n or Location		-		10d Inside City Limits
*	_	Maryland Carroll	Ma	nchester	•			1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at ouce.	Director	10e. Street and Number		10f. Z	ip Code	1	0g. Citizen of Wh	nat Country?
or 28		4300 E. Main St.			21102		U.S	Α.
should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once natic event, the Medical Examiner		11. Marital Status 12. Was Decede	ent Ever in U.S.	13. Was Dece		n? (Specify Yes or No		- American Indian, Black,
item ust b	Funeral	1 Never Married 2 X Married Armed Force 1 Yes	es?	If Yes, spe	cify Cuban, Mexican,	Puerto Rican, etc.)	White	
fter d		3 Widowed 4 Divorced If Yes, Give Year	Z NO	1 Yes	2X No specify:		Specify:	White
ours a	d b	15. Decedent's Education (Specify only highest grade of	completed) 16a		al Occupation (Give ki		16b. Kind of Bu	siness/Industry
72 hc	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	during most of w	orking life. DO NO T u	se retired)		
led within 72 Hygiene other than ' the Medical	립	12		Manager				ster Rescue Mi
Hygi Hygi othe		17. Father's Name (First, Middle, Last)				Name (First, Middle, I	Maiden Surname)
d be f ental arkec	Be	Jack McLean			The state of the s	Bryson		
es I and 2 should be fi of Health and Mental I If item 27 is marked her traumatic event,	2	19a. Informant's Name/Relationship (Type, Print) Robert Borrell - husband			•	per or Rural Route Num Manchester		
permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati		20a Method of Disposition		of Disposition (N	· .	Date		City or Town, State
es l a		1 Burial 2 Cremation 3 Removal from	State crema	atory or other plac	:e)			•
Pag ment tant: or ot		4 Donation 5 Other Specify:	Everg					nksburg, Md.
Depart Impor Injury	- 1	21. Signature of Funeral Service Licensee		² EName a	nd Address of Facility	al Chapel I	P.A.	24402
	-1	23a. Part I. Enter the disease, or complications that caus	ad the death. Do r					
ysician Medical		failure. List only one cause on each line.		not enter the mod	s or dynig, such as oa	raide of respiratory and	est, shock, of the	Between Onset and Death
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		_	State Registrar			Cei	rtificate	e of [Death		F	Reg. No.	100	12200
	Physicia		Decedent's Name (First, Middle,	Last)							Date of Dea Month	nth Day	Year	3. Time of Death
	/Medic	al -			BOETTCHE	R	45 City 3	Tour or	Lacation		April		006 nty of Death	8:25 p M
	Examin	er	4a. Facility Name (If not institution, § 6125 CHINQUAP)					LTIA	Location o	n Deam		N/		1
Og 5	Funeral		~	. Sex	7. Age (In yrs. Ia	st birthday)	If Under	1 Year	If Under		8. Date of Birth	h	9. Birth	nplace (State or Foreign
į,	Director		215-14-5915	1 □ M 2 /CX F	85	Yrs.	Months	Days	Hours	Min.	(Month, Day FEB 3			untry) IARYLAND
	pu 🛊 - un		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Limits
	Aaryla F shor	5			, , , ,			_					,	1 X Yes 2 □ No
	286-	Director	MARYLAND N/A 10e. Street and Number			BAL'	IMORE 10f. Zip					10g. Citizen o	of What Cou	untry?
	h with	D	6125 CHINQUAP	IN PARKW	AY			212	239			U.S.	Α.	
	ours after death with the Marylan al', or Iteme 23a or 28e-f show Examinat must be notified at	Funeral	11. Marital Status		edent Ever in U.S	S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. R	lace - Amer	rican Indian, e, etc.
36	or It	by Fu	1 XNever Married 2 Marrie	1 ☐ Yes If Yes, G	2 MNo ive	i	1 ☐ Yes 2		Specify:				cify: BLA	
21215-0036		ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or I	Dates:	16a. Dece	dent's Usua	I Occupa	ation			16b. Kind of		
15	nin 72 In "na Medic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College ((Give	kind of wor DO NOT us	rk done d	luring most	t of worki	ng			,
212	od within giene. er than "	Completed	12th grade	Conlege		SECI	RETARY	Z					ND ST	EEL
pu	be filed within 72 hc ntal Hygiene. od other than "natur event, the Medical	Be	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	(First, Middle,	Maiden Sum	ате)	
Уlа	should be and Mental Ind Mental Industries of umatic eve	ဥ	FRED BOETTCHE			10h Maili	a - Addensa	(Stroot o			RET C.	•—		in Code)
Maryland	S E S	1 15	Jacquelyn L. Nix		daughtor		3				Baltim			
	s 1 and 2 if Health itam 27 other tr		20a. Method of Disposition	COII/ GL ain	20b. Pla	ace of Dispo	sition (Nan	ne of			ate	20c. Locatio		
Baltimore,	0 0		1XX urial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	metery, cre ST HO1	-		1	04-1	3-06	ват.тт	MORE.	MARYLAND
alti:	_ 5 2 3		21. Signature of Euneral Service Li		1101	2:	2. Name an	d Addres	s of Facilit	ty				
ä	Departing Department of the poores.		1/5/5-	~			LLLIAN L206 V				MUNITY E	FUNERA	L HOM	E P.A.
***			232. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that nly one cause on	caused the death.	. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory an	1	-00	Approximate Interval Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. Con	plical	led (R) He	PIA	aclu	ne 5	econda	14 60	Fall	leas lan
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A		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a consequ	ence of):				^	المور		-9	
	nd rransi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						W	<i>N</i> -	HOIM	EXAMINE	
760,	ate be executed hysician and the burial-transit	al Ex	resulting in death) cast	Due to	(or as a consequ	ence of):					MOD CONTRACTOR APPROVE	ED BY WED		
687	tificate t ig physical as the t	<u> </u>		d						CENTRE	JCATION APP			
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	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as it	b	Part II. Other significant condition	s contributing to	death but not resu	ilting in the u	inderlying c	ause give	en in Part I	l.		obacco use c Yes 2 □ No		o the cause of death?
Records,	w requir been si should	Completed									24a. Was			itopsy findings available
Rec	ne law has l	di									autop	rmed?	prior to death?	completion of cause of
Vital		မ င	25. Was case referred to medical	1					26 Place	e of Deat	1 ☐ Yes	2 No	1 🗌 Yes	2 50 No
>	Physician: this certificanal director,	To B	examiner? 1 ☐ Yes 2 2 No	Hospital:	Inpatient 2 6	ER/Outpatie	nt 3 DC	Oth	or:		me 5 KResi		Other (Spec	cify)
u of	ng Ph ter th neral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	of 2	28c. Injun Worl	v at k?		28d. Describe I	now injury occ	curred	
Sio	Attending r death. ector: After by the fune	catle	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	y ho	-06	NA	М		Yes 2		5 he g	jen		
Division		Certification:	4 Homicide determin	led build	e of Injury - At ho ding, etc. (Specify		reet, factory	y, office			City or To	vn, State) 6	125 Chi	inquapin Pkwy.
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	aC	29a. Certifier 1 Certifying	At ho	ne best of my know	wledge, dea	th occurred	at the tin	ne, date ar	nd place,	Baltimore and due to the	cause(s) and	manner as	stated.
	n 24 h	edical	(Check only 2 Medical E	xaminer: On the and ma	basis of examinat nner stated.	ion and/or in	nvestigation	, in my o	pinion, dea	ath occur	red at the time,	date and place	e, and due	to the cause(s)
	To the To the Complex complex	Σ	29b. Signature and title of certifier	Tax	RING	eeri	290	c. Licens	e number	1		29d. Date sig	ned (Monti	7. Day, Year)
	Ω		- Juliana		U		1			-	1	The way		_
	5		30. Name and address of person w	ho completed car Raver	use of death (Item	23a) (Type	Bal	lia	riole	' '	91A -	212	39	
17	Sta	ate	31 Date filed (Month, Day, Year)	G2.	Registrar's Signat	ture	-459							
	Regist	rar	APR 1 9 20	06	cas SE	A 1924								

			For State Registrar	State of Marylar		rtment of F		Mental Hygie	4000	12202
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
E	Physicia /Medic		IRMA	BRENNER	2			APRIL 1	Day Yeer	120M
A. C.	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of Deat	_	4c. County of Dea	112-6
			Nontarivation H. 5. Social Security Number 6. Sex	7	NEN	If Under 1 Year	If Under 24 Hrs.	1	BALTIM	
	Funeral Director			M 20 F	. last birthday) _ 80 Yrs.	Months Days	Hours Min.	JUNE 14,1	925	thplace (State or Foreign ountry) MD
	ס		Usual Residence of Decedent							
	anylan show	<u>.</u>	10a. State 10b. County		ity, Town or Loca					10d. Inside City Limits
	he Ma	ecto	MD BALTIMO	RE	KE12	TERSTOWN		10-	035	1 ☐ Yes 2 No
	with t	Funeral Director	300 SALONY DRIVE	#202		10f. Zip Code	21136	Tog.	Citizen of What Co	USA
	death	era		2. Was Decedent Ever in U	J.S. 13. W	as Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican fndian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other then "naturel", or Items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 🗖 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puèri Specify:	o Rican, etc.)	Black, Whit	e, etc. WHITE
5	"natu	Completed by	15. Decedent's Educ (Specify only highest grade		(Give k.	nt's Usual Occup ind of work done O NOT use retired	during most of wo	rking 16b	. Kind of Business	findustry
12	withir ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	SECRET		J)	FE	DERAL GO	VERNMENT
	filed Hygi other	0	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, Max	den Sumame)	
Maryland	uid be Jenta rrked ric ev	To B	ISRAEL		LEVI	N	DORA			SOLOMON
lar)	2 sho and f	3	19a. Informant's Name/Relationship (Type	·				iral Route Number, Ci		
	l and lealth om 27 her tr	1 8	DORRIE ROSEN / DA 20a. Method of Disposition	UGHTER	245 Place of Disposi		ER COURT	- WESTMIN	Location - City or	
Baltimore,	Pages ment of h ant: if its ury or of		1 🛱 Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crema	atory or other plac	ERY 04/1		BALTIMOR	
3alt	Departit. Departit Import eny in		21. Signature of Funeral Service License	9 7		Name and Addre		OL LEVINSO		
	205 e d		23a. Part1. Enter the disease, or complic	vations that caused the dea				ROAD - PI	KESVILLE	MD 21208 Approximate
	20.7		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
P	Physician / /Medical		disease or condition resulting in death)	Due to (or as a conse		mer/1	1752	cerosny		
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.O. Box	The law requires that the death ceriffic sie has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. ff yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	aldeath 3 □E	Ectopic pregnancy Other (specify)	′		23d. Date of de Month	ivery Day Year
Δ.	res that tigned by		Part If. Other significant conditions con	tributing to death but not re	sulting in the und	derlying cause giv	en in Part.J.	23e. Did tobac	co use contribute to	the cause of death?
rds	quires an sign uld be	ed by	Aspiration Sy	vanome:	ATRIAL	JERAL'L	lation "	1 ☐ Yes	2 ☐No 3 ☐ Pi	obably 4 Unknown
000	e law requii has been s je 2 should	plet	SHERAL DEC	Bitus u	lens		7	24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
of Vital Records,		Completed						performed	? death?	22 No
/ita	Physician: 1 this certificer ral director, p	Be (25. Was case referred to medical examiner?			100		ath (Check only one)		
of)	9 0 7	6	1 Yes 2 No	ospital:	ER/Outpatient 28b. Time of		4 🗀 IVursing r	lome 5 Residence		cify)
O	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injur Wor M 1	k? Yes 2 □ No	280. Describe now i	njury occurred	
Division	i or Attending after death. Director: Afte in by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At I				28f. Location (Stree	tand Number or Ri	ural Route Number,
Ö	tel or A rs after el Dire ed in by	Certification;	4 Hornicide	building, etc. (Spec	ary)			City or Town, S	ra(e)	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier (Check only one)	ician: To the best of my kn er: On the basis of examin and manner stated.	nowledge, death nation and/or inve	occurred at the tirestigation, in my o	me, date and place pinion, death occu	a, and due to the caus urred at the time, date	e(s) and manner as and place, and due	s stated. a to the cause(s)
	To the I within 2 To the I complet	Ž	29b. Signature and title of certifier	1 .		29c. Licens			Date signed (Mont	
	/		Africa	of his		121	9502	Ä	PRIL (7, 2006
	5	å	30. Name and address of person who co			rint)	18C127+10	SN MA	SPITAL	Renton
	Sta	to.	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature -	Ryta	BALLE CO	IN MA	ig CAND	41133
	Registr		APR 1 9 200	32 Registrar's Sign	H Los	Bi			t	
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			For State Registrer	State of Maryland / D		tment of Heificate of L			giene	106	12203
H	Physici	an	1. Decedent's Name (First, Middle, Last Carolyn Le)				2. Date of Dea Month April		OO6 Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Dea		_	County of Deat	10:45PMM
	Examin	er	Southern Maryland			Clinton				ince Ge	
	Funeral Director		5. Social Security Number 6. Se 213-38-3549	711 - 877 5 6 1	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h v, Year)	9. Birtl	nplace (State or Foreign untry)
	P >		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Loca	ation					10d. Inside City Limits
	Aaryla Fehor	or	Maryland Charles	100.00,700		anjemoy					1 Yes 2 TNO
	28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	th with	ai D	9296 Bay View Pla	ce			20662		U.	S.A.	
36	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other then "natural", or iteme 23s or 28s-f ehow eumatic event, the Medical Exam an must be taxified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		as Decedent of His Yes, specify Cubar ☑ Yes 2 ☑ No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		4. Race - Ame Black, White Specify: Whi	e, etc.
21215-0036	2 hou stura ical E	ted	15. Decedent's Ed	ucation 16a.	Decede	nt's Usual Occupa	ition	orkina		d of Business/	
215	thin 7 e.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		ind of work done d O NOT use retired))	TKIII		nce Geo nty Sch	
2	led wi		12th 17. Father's Name (First, Middle, Last)	Tea	ache	rs Aide	18 Mothode No	ime (First, Middle,			10018
Baltimore, Maryland	should be filed vand Mental Hygies smarked other tournatic event, to	o Be		Shackelford				thy Lee F			
ΣŽ	should nd Me mark	2	19a. Informant's Name/Relationship (7		. Mailing	Address (Street a		Rural Route Numbe			Zip Code)
Ž	alth a alth a 27 is		Oscar Collins (Hu	sband) 9	9296	Bay View	v Place	Nanjemoy	, Mai	ryland	20662
ore,	permit. Pages 1 and 2 should Depertment of Health and Men Important: If Item 27 Is marke eny injury or other treumatic ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. Place of cemeter)	Disposi ry, crema	ition (Name of atory or other place	e) Apr	il 21,	20c. Loc	ation - City or	Town, State
Ĕ	Pag ment tant: I		4 ☐ Donation 5 ☐ Other (Specify	Trinit		emorial (Gardens	2006		dorf Ma	
Ball	Depermit Depermit Impor Impor eny in		21. Signature of Funeral Service Licen:	M01464		Name and Addres		ee Funer			
_	4		23a Part1. Enter the disease, or comp	dications that caused the death. Do n						Clinto	n , MD20735 Approximate
5.38	Dhusisian		shock, or heart failure. List only of immediate Cause (Final	ine cause on each line.		0					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or aş a consequence o		in	29				1 minter
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_	cate be executed physician and the burial-transit	Examine	that initiated events resulting in death) Last	cDue to (or as a consequence of	of):	n #1181	1				
8760,	be exician buria	dical E		, ,	,						
687	ficate g phys	edic		d							
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)	,		20	3d. Date of del Month	ivery Day Year
۵	res that t igned by be deta		Part II. Other significant conditions co	ontributing to death but not resulting in	n the und	derlying cause give	n in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
rds,	requires that been signed b hould be deta	ed by	Carbonne	uld Godide	nt			101	res 2□	No 31X Pr	obably 4 Unknown
900	aw Is b	Completed	Brann In	Jasta Sis.				24a. Was	an	24b. Were au	topsy findings available completion of cause of
Ä	The ate h page	Com						perfo	rmed?	death?	2 □ No
/ita	iclan: certific rector,	Be	25. Was case referred to medical examiner?	Unanitati		Othe		eath (Check only o	ne)		
of Vital Record	Phys this al di	-T	1 ☐ Yes 2 🗽 No 27. Manner of Death	Hospital: 1 Inpatient 2 EP/Out	tpatient Time of		4 🗀 1401 Siriy	Home 5 Resid			cify)
	E 5	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Ir	njury	28c. Injury Work	(?`` ∕es 2⊡No	200. 2000.20		00001100	
Division	tel or Attending s after death. el Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ırm, stre	et, factory, office		28f. Location (S City or Tox		Number or Ru	iral Route Number,
Ω	Hospitel of 24 hours all Funerel Distely filled i		29a, Certifier 1 Certifying Ph	ysician: To the best of my knowledge	a doath	coourad at the tim	o date and play	and due to the	cauco(s) s	and manner as	stated
	24 ho 24 ho Fun etely	Medical	(Check only 2 Medical Exam	niner: On the basis of examination and	d/or inve	estigation, in my op	pinion, death occ	curred at the time,	date and p	place, and due	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	#2004 = 1		29c. License	number		29d. Date	signed (Monti	h, Day, Year)
	10		/ //mfanu	MO		D	2082	7	4)	7/06	
1	21		30. Name and address of person who	completed cause of death (Item 23a) (WC. #18 Apple App	(Type, P	Print)		m) \	Prof ~	
			31. Date filed (Month, Day, Year)	Registrar's Signature	R	11/312/5	ORD	1111	101	12	
	St: Regist		APR 1 9 200	6 Serve A A	1500						

			For Amend Items State Registrar	24 5 1329,2584	yland Dep Cei	854904919 rtificate of	706 In B ^{d Me} Death		ene 1. No.	12204
	Physicia		1. Decedent's Name (First, Middle, Li Harold		en		2	Date of Death	Day Year 7 2006	3. Time of Death 12'12P M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of Death	yiii i	4c County of Dea	
			Doctors Hospita		4 - 1 - 4 - 1 - 1 - 1 - 1	If Under 1 Year	76 ∼ If Under 24 Hrs. 6	Date of Righ		rthplace (State or Foreign
	Funeral Director			Sex 7. Age (1.26 M 2 □ F	In yrs. last birthday) 80 Yrs.	Months Days	Hours Min.	Date of Birth (Month, Day, Y	(ear) C	cion Co. Chio
	D		Usual Residence of Decedent 10a, State 10b, County	11	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla -f ehor	tor	OH Frank			olumbus				19€ es 2 □ No
	or 28a	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	Country?
	e 23e	eral	4426 North 4th	n Street 12. Was Decedent Ev	er in U.S. 13.	4322 Was Decedent of H	lispanic Origin? (Spec	fy Yes or No-	USA 14. Race - Arr	erican Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural; or Iteme 23a or 28a-f show amy njury or other traumatic event, Ite Medical Examinal must be indiffied at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3€○N/Vidowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2€3€No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes ※ No	an, Mexican, Puerto R Specify:	can, etc.)	Black, Wh	ite, etc. /hite
2-0	72 ho	eted	15. Decedent's I (Specify only highest g	Education rade completed)	16a. Dece (Give	dent's Usual Occup	pation during most of working d)	7	6b. Kind of Busines	-
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	i 2 should be filed within h h and Mental Hygiene. 7 is marked other than " traumatic event, to Me.	Be	17. Father's Name (First, Middle, Las	• Coen			18. Mother's Name	First, Middle, Ma R. Thew	aiden Sumame)	
Maryland	d Men marke	2	Jennings H 19a. Informant's Name/Relationship		19b. Maili	ing Address (Street	and Number or Rural		City or Town, State	Zip Code)
	alth an 27 is in traus		William Smith				one Place	College	Park MD	20740
Baltimore,	Pages 1 and of Height: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Glenda	osition (Name of matory or other pla Le Unior	Cem. 4/	15/200	oc. Location - City of Cardin	or Town, State
Balti	permit. Departn Importe any nju		21. Signature of Funeral Service Lic	7		1501 East	. Stevens Fu Fort Ave Ba	ltimore M	D 21230	
			23a. Part1. Enter the disease or co shock, or heart failure. List on	piplications that caused to y one cause on each line	ne death. Do not en	iter the mode of dyi	ng, such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	u	Consequence of):	PNEN	IONIA			4 das
	Examiner		Sequentially list conditions.	RESPI	RATORY	FAILL	RE			2 days
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68760,	cate be physici the bu	dlcal		d. LUNG	CANCER					
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ر Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	26. Place of Death			
of	Phys r this ral dii	n: To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju	4 Nursing non		nce 6 Other (S) w injury occurred	oecity)
ion	Attending For death. ector: After by the funer	atlo	1 Natural 5 Pending 2 Accident investigat	07.01.0)	M 1]Yes 2 □No			
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			30. Name and address of person w	no completed cause of de	18 Good	LUCK	Rd, Lan	ham m	1 201	106
100	St Regis	ate trar	31. Date filed (Month, Day, Year) APR 1 9 2006	32. Registra	r's Signature	,				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:15 A. **Physician** Helen Carrier April 15, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert 3015 Ashwood Drive Dunkirk | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 18, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F 82 Yrs. 579-38-5374 Pennsylvania Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10b. County Il Hygiene. other then "naturel", or iteme 23a or 28a-f show vent, the Modical Examiner must be notified at Maryland Dunkirk 1 Yes 2 □ No Calvert Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 Ashwood Drive 20754 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X Yes 2 □ No If Yes, Give 1945–1946 Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Medical Registered Nurse rmit. Pages 1 end 2 should be filed w portment of Heelth and Mental Hygies portent: If Item 27 is marked other till jinjury or other treumatic event, IL. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pearl L. Spicher Joseph Meyers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3015 Ashwood Drive, Dunkirk, MD 20754 Robert L. Carrier/Son Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 4/17/2006 Odenton, MD 1 Burial 2 Cremation 3 Removal from State West Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) permit.
Depurtulmporte any inju 22. Name and Address of Facility Columbia Mortuary Services, Inc. 21. Signature y Funeral Service Licensee P.O. Box 58007 Washington, D.C. 20037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTED Physician RUPTURFD ABDUMINAL AURTIC ANFURTSM /Medical Due to (or as a consequence of): Examiner THERO SCIENTE CARTIOVASCULAR DISHASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien end the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical th. ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the et d be detached fo 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DISMAGE TENSION- CORONARY ARTER-1 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate las b director, peg. 2 s 1□ Yes 2LX No Division of Vital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 1 Yes 2 No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours efter death.

To the Funerel Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AW9786611 APRIL 17,2006 M/ luge address of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK MIJ-20678 WEIGE Mi 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar 9 2006

Chare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg No. JU 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April10, 2006 Physician Gladys Chase 3:20PM № /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TYF 214-30-1132 73 July27,1932 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ir than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Yes 2 No MD Prince Georges Clinton Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7809 Marwood Dr. 20735 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Providence Hospital Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill iment of Health and Mental Hiant: If Item 27 is marked ot Roy Moore Rosie Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Moore?Brother 7809 Marwood Dr. Clinton, MD 20735 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition Asbury United 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or once. 4/15/06 Brandywine, MD Meth Church 22. Name and Address of Facility Adams Funeral Home, PA 21. Signature of Funeral Service License 20605 Aquasco Rd. Aquasco, MD 20608 23a. Part1. Enter the disease, or complic shock, or hear failure. List only soe Approximate Interval Between Onset and Death plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, age cause on each line. Immediate Cause (Final ATheroscherotic Cardis vorolan Discon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 well UKINAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and deed be detached for use es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peeu (24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has page 2 certificete 2/2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending Natural 1 ☐ Yes 2 ☐ No death investigation neral Director: A filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complataly 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4-11-2006 DK5365 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H70/ livings to NO Et lol, ft wastigte in 20744 MA 31. Date filed (Month Da State Registrar

			For State of I	Marylan		rtment of F tificate of	lealth and M <i>Death</i>	lental Hy	giene Reg. No:	UUn	12207
			Decedent's Name (First, Middle, Last)					2. Date of Do Month	eath Day	/ Year	3. Time of Death
	Physicia /Medic		Mignon Alger Bell	Camero	n			4	15	3 06	
	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and numb 1. Social Security Number 1. Security Number 6. Sex 1. M 2 X F	Age (In yrs.	SD, tal last birthday) Yrs.	4b. City, Town, o	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Bir	th MCRE Thiplace (State or Foreign country)
*	D >		Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc	ation					10d. Inside City Limits
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	the Maryla 28a-f ehor	rect	10e. Street and Number		7111	10f. Zip Code			10g. Cit	izen of What C	ountry?
6	23a or	<u>a</u>	310 N. Tollgate Road			21014			11	SA	
NON S	death	Funeral Director	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.	.S. 13. W		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or N Rican, etc.)		14. Race - Am Black, Whi	
J 98	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Madical Examinar must be motified at	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2: If Yes, Give Year or Date	No		□Yes 2√2 No	Specify:			Specify:	
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	rt 2 mg		Annette Blum - Daughter		1437	Eagle Ric	dge Run, 1	Bel Air	c, Ma	ryland	21014
je Z	es 1 and 2 of Health fitem 27 ir other tra		20a. Method of Disposition	20b. P	— Place of Dispos cemetery, crem	sition (Name of latory or other pla	ce)	Date	20c. Lo	ocation - City or	r Town, State
$\mathcal{CQ}_{\mathcal{A}}$ Baltimore,	Pag nent ant: I		Durial 2 □ Cremation 3 □ Removal from St. Donation 5 □ Other (Specify)	ale	rlingto		4/18	/06	Darl	ington,	Maryland
agr.	permit. Pag Department Important; I eny injury o		21. Signatur 1 Funeral Service Licensee	1		Name and Addre					ne, P.A.
ш	go E a g		23a. Part 1. Enter the disease, or complications that one							, Mary	Land 21009
			shock, or heart failure. List only one cause on each	sh line.	in. Do not ente	er the mode of dyn	ng, such as cardiac	or respiratory	arrest,		Interval Between Onset and Death
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×o	eath certifi ettending I for use as	Z.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the program of the pr			Estania seconda				23d. Date of de	elivery
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or or	w requir been s	eted						24a. Wa		1	utopsy findings available
Division of Vital Records,	(a) (c)	Completed						aut	opsy formed?	prior to death?	completion of cause of
tal	ysician: The l is certificate ha director, page	0	25. Was case referred to medical				26. Place of Deat		2 Д No	1 1 10	\$ 2□ No
ž	ysicii is cer direct	To B	examiner? 1 Tes 2 No Hospital: 1 Ming	patient 2	ER/Outpatien	t 3 DOA	her: 4 Nursing Ho			6 □Other (Sp.	ecify)
Ö	ding Phy h, After thi tuneral	ino	27. Manner of Death 28a. Oate of 1 Natural 5 Pending (Month,	Injury , <i>Day Year</i>)	28b. Time of Injury	28c. Inju Wo	ry at ork?	28d. Describe	how inju	ry occurred	
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Jivi	or At after d Direct in by	Certification;	determined 288, Place of	of Injury - At h g, etc. <i>(Specil</i>	fome, farm, stre	eet, factory, office			own, State		Rural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Euneral Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner and manner control of the base and manner con	sis of examina							
	To th within To th comp	Me	29b. Signature and title of certifier	MD		29c. Licen	se number 5 7 7 0 _3	3	29d. Da	ite signed (Mor	nth, Day, Year)
	20		30. Name and address of person who completed cause	of death (Ite	m 23a) (Type,	Print)					
_	σ		DR. Suman Barryur	Rao	90	00 4E	Canklin So	ucice D	R. P	xaltim	DRE, MD 2123
	St Regist	ate	31. Date filed (Month, Day, Year) APR 1 9 2006	gistrar's Sign	de la la la la la la la la la la la la la	K)					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 14, 2006 **Physician** 10:47 PMM Jose' Antonio Colon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/22/1946 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Peurto Rico 59 Months Days Hours Min 18M 2 F 092-36-9268 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f ehow other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No MD Baltimore Dundalk Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 6544 Rabon Avenue Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 11X Yes 2□ No Specify: Puerto Rican Specify: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Construction le marked other then Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit.
Department of Health and Mental ty,
Important: if Item 27 Ie marked oth
eny lighry or other traumatic even
one. Be Jose' Antonio Colon, Sr. Maria Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Colon/Wife 6544 Rabon Avenue Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Apr 18 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland 2006 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final edra **Physician** 1 Ver disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by disease 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate hes 1 Tes 2√2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural 5 Pending death. 1 ☐ Yes 2 ☐ No safter death.
I Director: A in y the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 025205

Registrar

DHMH 17 Rev 1/2001

State

6701

N. Chales St.

Balto MN 21204

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

9 2006

31. Date filed (Month, Day, Year)

BMC

32. Registrar's Signature

			1 - For State Registrar		State of	of Maryla		artment of F			lental H	gien Reg. N	2006	a post	12209
E			1. Decedent's Name (First, Midd.	e, Last)							2. Date of D	eath Da	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		3. Time of Death
	Physici /Medio		Kevin D.	nicki	ett						Month 03	3	*	ear 6	4:50 A M
	Examin		4a. Facility Name (If not institutio			ımber)		4b. City, Town, o	r Locatio	on of Death		44	c. County of [Death	
			Clinton Nursi	ng &	Rehal	oilitat	ion	Clinto					Prince		
	Funeral		Social Security Number	6. Sex	M 2□F	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Und	der 24 Hrs.	8. Date of B (Month, D	irth ay, Year	9.	Birthpl Count	ace (State or Foreign try)
	Director		577-94-9627 Usual Residence of Decedent			33	Yrs.				02 2			shi	ngton, D.C
	and and		10a. State 10b. County			10c. (City, Town or Lo	ocation						10	Od. Inside City Limits
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	death	Funeral	1200 North Ca	1	2. Was Dec	edent Ever in	U.S. 13.	Was Decedent of H	lispanic	Origin? (Sp	ecify Yes or N	0-	USA 14. Race - A		
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-	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Cynthia Duck	ett/	Wife	Tan		No. Capi	to1						
ore	ges 1 of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Re	moval from		cemetery, cre	osition (Name of matory or other plac	ce)		Date	20c. L	ocation - City	y or Tov	wn, State
Ξ	Pag Imeni Iant:		`4 ☐ Donation 5 ☐ Other (5	pecify)			t. Line	coln Cem.		04-0	7-06	Br	entwoo	d, 1	MD.
Банито	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		21. Signature of Funeral Service	-	()	10		2. Name and Addre							
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			23a. Part?. Enter the disease, o shock, or heart failure. List	only one	ations that cause on	caused the de each line.	ath. Do not en	er the mode of dyin	ng, such	as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
è	Physician		Immediate Cause (Final disease or condition resulting in death)	_ a.	Enc	ephalo	paty								Onsor and Boats
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Ď	death a atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		4□Preg	birth 2□Fe nant at time ol]Ect <i>o</i> pic pregnancy] Other <i>(specify)</i> _	/				Month	(Day Year
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coras,	quire an sig		End Stage F	lena]	Dise	ase					1 🗆	Yes 2	2 □ No 3 □] Proba	ably 4 Unknown
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Ĕ	r Att ter de irect	ertification;	3 Suicide 6 Could 4 Homicide determ		28e. Place build	e of Injury - At ling, etc. (Spe	home, larm, str	reet, factory, office			28f. Location City or To			r Rural	Route Number,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 ☐ Certifyii (Check only 2 ☐ Medical	ng Physi Examin	er: On the b	pasis of exami	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date pinion, d	and place, death occurr	and due to the red at the time	cause(s date an	s) and manne id place, and	r as sta due to	ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** ELIZABETH DENNING 2015PM APRIL 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayvian Care Center Baltimore N/A 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 K F Months Hours 215-09-5919 Maryland Director 21,1912 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exercities trust be notified at 1 TYes 2 No Dundalk Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ŏ 21222 9 Arrowship Road Items 23a United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 □ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Nidowed 4 Divorced White "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Glass Inspector Glass Company 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental F Mary Kraft Charles Myers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Arrowship Road Dundalk, Maryland Health tem 27 I Sharon Price (Daughter) item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō = ™Burial 2 Cremation 3 Removal from State 0 Department of Importent: If any injury or Baltimore, Maryland Louden Park Cemetery 4/19/2006 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Part1. Enter the disease, or shock, or heart failure. List on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician stall dementia 51d /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown ρ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 Yes 2 No 3 Probably 4 Unknown Small bowel obstruction, osteoarthritis typutension, Completed 24b. Were autopsy findings available prior to completion of cause of death? macular deseneration 24a. Was an has autopsy 2□ No certificate 1 ☐ Yes 2 No 1 Yes Division of Vital Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Hospital or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funerel Direct 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Fo the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ln 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopking Baynew Girde VICTOR CRENTSIL MD 2202 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Barrens . 9 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Month Year April 16, 11:00 AM Charles G. Dollenger Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 5301 Selfridge Avenue Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 11/03/1936 69 Yrs. 213-34-2659 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Show 10a. State 10b. Count ir then "naturel", or Iteme 23a or 28a-f shov Ite Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5301 Selfridge Avenue 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1955-57 Specify: 3 ☐ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Trucking Driver 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othly any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles A. Dollenger Antoinette K. Tribull 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 Main Street Harleysville, Pennsylvania 19438 Andrew C. Dollenger - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/18/2006 Baltimore, Maryland Bayview Crematory 21. Signatore of Funeral Service Light see David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore Maryland 21231 Vains 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute myocardia /Medical Due to (or as a consequence of Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine g physician and as the burial-transit Due to (or as a consequence of). P.O. Box 68760 Physician/Medical attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No cance Completed COPD 24b. Were autopsy findings available prior to completion of cause of death?
t □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2/5 No cancer pladder 1 ☐ Yes I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital or within 24 hours aft To the Funerel DI Centifying Physician: To the best of 'ty' knowledge death occurred at the time. Sate and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2tin Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Sharon Belanson \$D0055157 4/18/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Point Rd. 9600 SHARON BALANSON Fort Howard 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

FFEMALE: 23d. Date of delivery 23d. Date of deli			1 - For Stata Registrar	State of	f Maryland	-	artmen rtificat			and M		giene Rog. No.	36	2212
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30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Physic rthis or ral dire			1 1 1				JA	4 140					9
30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nding Path.	ton:	1 XX atural 5 ☐ Pending	(Mon	th, Day Year)			Worl	</td <td></td> <td>tou. Describe i</td> <td>now injury oc</td> <td>Culled</td> <td></td>		tou. Describe i	now injury oc	Culled	
30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Attence at death ector:	ficat	3 Suicide 6 Could not I	e 28e. Place	of Injury - At ho	me, farm, sti				-			umber or Rura	I Route Number,
30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	after Dire	erti	4 Homicide	buildi buildi	ng, etc. <i>(Specit</i>)	1)					City or Tov	vn, State)		
30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Mospita 24 hours Funere etely fille		(Check only 2 Medical Exa	minar: On the b	asis of examinat									
30. Name and address of person who completed cause of death (Item 13a) (Type, Print) Allen Reilly, M.D. 801 Toll House Avenue D-1 Frederick, Maryland State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To the within To the		29b. Signature and title of pertifier	0	-11		29	c. License	e number			29d. Date si	gned (Month, I	Day, Year)
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State	11				- / /	/		ue I	0-1	Frede	erick,	Maryla	ınd	
					ngistrar's Signa	ture	248							

		State of Man		artment of H			ene 006	12213
Physici /Medio		1. Decedent's Name (First, Middle, Last) Bessie Virginia Elliott				2. Date of Death Month April	Day Year 13, 2006	3. Time of Death 8:35 P M
Examir		4a. Facility Name (If not institution, give street and number) 2832 Washington Blvd 5. Social Security Number 6. Sex 7. Age (I	n yrs. last birthday)	4b. City, Town, or Baltimo		8. Date of Birth	4c. County of Death	pplace (State or Foreign
Funeral Director		1□N 2451E	37 Yrs.	Months Days	Hours Min.	(Month, Day, 1	, 1918 West	intry)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Maryland n/a 10e. Street and Number 2832 Washington Blvd	Oc. City, Town or Lo Balt	imore 10f. Zip Code 21230			g. Citizen of What Cou	•
nours after deat urai', or items?	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	Specify:		14. Race - Amer Black, White Specify: Wh	ite
within 72 hisene. Jene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5 0	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, maker	ition furing most of work)	ing	6b. Kind of Business/li home	ndustry
uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) George Meumaw	1101110		18. Mother's Nam Ethel u	e (First, Middle, Ma nknown		
and 2 sho		19a. Informant's Name/Relationship (Type, Print) Brenda Mae Fernandez – child	2832	Washingt	on Blvd,	Baltimor	City or Town, State, Z Ce, Marylar	nd 21230
Pages 1 iment of Hi tent: If iten		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Cedar Hil	natory or other place L1 Cemeter	4/17/		oc. Location - City or 1	rk, Marylan
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The ate h	e Completed			·		<u> </u>	ed2 prior to c death? MNo 1 ☐ Yes	opsy findings available ompletion of cause of
Attending Physician: 1 r death. sctor: After this certifical by the funeral director, p	To B	25. Was case referred to medical examiner? 1		f 28c. Injury Work	9r: 4 🗌 Nursing Ho	h Check only one ome X Residen 28d. Describe how	nce 6 Other (Spec	ofy)
in Sign	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, sti Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of response to the best of examiner: On the basis of examiner and manner state.	amination and/or in	vestigation, in my or	oinion, death occur	red at the time, dat	te and place, and due	to the cause(s)
To To To man	Σ	29b. Signaturo and title of certifier Konnel C. Taurb			neceo	A	mil 14, 2	•
, A		30. Name and address of person who completed cause of deal Rubert C. Dout, 1, 901	th (Item 23a) (Type,	Print)	Baltime	re imp). 2127	0
St: Regist	ate rar	31. Date filed (Manp) (Pay) Year) 2006	Signature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day April 11, 2006 Mildred G. **Physician** 12:25PM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Southern Maryland hospital Clinton Prince George's Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 XXF 577-58-2601 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts 17 is marked other than "natural", or items 23a or 28e-1 show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11201 Old Marlboro Pike U.S.A. filed within 72 hours after deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Education 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h James Henry Wesley Kate C. Stansbury ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: if Item 27 is rr any Injury or other traum <u>once.</u> 11301 Brooklee Drive Upper Marlboro, MD 20772 Lois Miller (Daughter) 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State April 17, Cedar Hill Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, inc. 21. Signatury of Funeral Survice Lice and wet 6633 Old Alexandria Ferry Road Clinton, ND20735 1100151 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician ADVANCED COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physicien and d be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 1☐Yes 2√ No 9☐Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TWSUFFICENCY 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Medical Certification: To 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospitel o within 24 hours aft 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50862 APR56, 12, 2006 Human 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif Hassan MD 9831 Greenbelt Road Suite 103 Lanham, MD 20706 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 9 2006

			1 - For State Registrar	State of	Maryland		rtment o			and Mei		giene Reg. No.	006	12215		
	Dhusisi		1. Decedent's Name (First, Middle,	ast)						2.	Date of Dea Month	ith Day	Year	3. Time of Death		
	Physici /Medio		Rosalie Yerkes	Figge						Ar			006	10:45 PM		
	Examin		4a. Fecility Name (If not institution, g	rive street and num	ber)		4b. City, Town, or Location of Death						4c. County of Death			
			Stella Maris		Timonium						re					
	Funeral		,	. Sex 1 □ M 2 🖾 F	Age (In yrs. la	st birthday) Yrs.	If Under 1 Y Months D	ays	If Under : Hours	24 Hrs. 8. Min.	Date of Birti (Month, Day	Yeer)	9. Birth	place (Stete or Foreign intry)		
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	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits		
	Mary -i sh	tor	MD Balt	imore	Tr.i.									1 ☐ Yes 2√ No		
	roti	Director	10e. Street and Number	Imore		nonium	10f. Zip Co	de				10g. Citiz	en of What Cou	intry?		
	h with	o ie	2300 Dulaney Va	11ev Road	i		210	202				U	SA			
	deat	Funerai	11. Marital Status		dent Ever in U.S		Vas Decedent Yes, specify)93 t of Hisp	panic Orig	gin? (Specify	Yes or No-	1	4. Race - Amer			
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Maryland	d la b	Be c	Dawson Martin Y													
Σ	should ind Men marke umatic	L C	19a. Informant's Name/Relationship			19h Mailin	n Address /S				ace Ha		Town, State, Zi	n Cade)		
<u>⊠</u>	nd 2 suith an 27 is r trau				.T. 4											
	E 3 6 8		Rosalie Ann Bea 20a. Method of Disposition	siey/daug	20b. Pla	ace of Dispos	sition (Name of	of	ert	Road Date	Lecna	20c. Loc	wne . M	20650 own, State		
altimore,	permit. Pages 1 Department of H Important: If Ite any injury or ott		1 Burial 2 Cremation 3		tate Cei	metery, creп	atory or other	r piace)								
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	76		Baltimore, MD 21201 23a. Pett1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
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Box	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc			Cataolia ausan					23	d. Date of deliv	өгу		
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	The te h	e Completed									autops perfori	ompletion of cause of				
<u>ra</u>	Physician: Th this certificate ral director, pag		25. Was case referred to medical						6. Place	of Death (C	1 ☐ Yes heck only or	No No	1 🗆 Yes	20-10		
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	e Hospital or 24 hours afte e Funeral Dir letely filled in	Medical	29a. Certifier (Check only one) 1											stated. o the cause(s)		
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			Grace L. Fig	sher						1			3, 2006 22:45 P ^M			
			4a. Facility Name (If not institution, gi		r)		4b. City,	Town, or	Location of	f Death			4c. County of Death			
			Upper Chesapea	ake Medica	l Cen	ter	Bel	Air				H	arfor	d		
4-	Funeral Director	-5.		Sex 7. A 1 □ M 25€ F	ige (In yrs	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Birt (Month, Day 101. 21	v. Year)	017		ace (State or Foreign ry) sylvania	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Items 23a or 28e-1 show injury or other traumatic event, the Medical Examinar must be notified at injury or experiment.		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	ocation				pr. 21	, 1)		d. Inside City Limits	
		ector	Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country?											1 ☐ Yes 2X No		
		Funeral Director	311 Princeton Lane 21014										USA			
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036	72 hours after natural', or Ita	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Dates	No		1 🗆 Yes			, 1 40/10 11	ioan, oto.)		Specify:		hite	
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Maryland 2	d be filed antal Hygi tad other c svsnt, I	Be C	17. Father's Name (First, Middle, Las Charles A. Berge								^{(First, Middle,} Wanner		Sumame)			
aryl	thould Me	은	19a. Informant's Name/Relationship			19b. Maili	na Address	(Street a			Route Numbe		or Town Sta	ate. Zio (Code)	
	and 2 sho ealth and m 27 is m	1	Marlene G. Butler			311	Princ	eton		Bel	Air, M	D 2	1014			
more	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 2002.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Contents)		Place of Disposition (Name of remetery, crematory or other place) airview Cemetery 4-18				Da 1–18–1			Location - City or Town, State Ltztown, Pennsylvania				
Baltimore,			21. Signature of Funeral Service Licensee 22. Name and Address of Facility													
760,	The law requires that the death certificate be executed safe and grade as the attending physician and page 2 should be detached for use as the burnal-transit	cal Examiner	MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											- / . //		
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		þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc									o use contribute to the cause of death?				
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a	sicien: Th certificate rector, pag	e C	25. Was case referred to medical	1									Mo 1 Yes 2 No			
₹	ding Physicien: th. After this certifica funeral director, p	- □	examiner?	Hospital: Cther												
of	Phy r this ral d	. To	27. Manner of Death	28a. Date of In		28b. Time o	IL SLI DOA		4 Nursing nor				6 ∐Other (Specify)			
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Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	ertifica	2 Suivide 6 Could not be								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_		Medical Certification:	29a. Certifier Certifying P	(Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										ted. the cause(s)		
	To the within To the comple	Me									29d. Da	Date signed (Month, Day, Year)				
	, 5		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type,	Print)	JJY	4 1	· ·		Apr	1/ 14	10	06	
	10		Scott Huice	U1/1	2 No	with /	Juine	K	131/	Bir	Mary	1/40	10	d 10	"	
700	Sta Registi		31. Date filed (Month Day, Year) APR 1 9 20	06 Elecus	J. 10	And	West of the second									

DELORES M. GRAHAM

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please	Type or Print in				-		
		1 - For State Registrar	State of Maryla	-	artment of H rtificate of I		ntal Hygier	6.000	12217
330	¥ . §	Decedent's Name (First, Middle, La	ist)			2	. Date of Death		3. Time of Death
Physicia /Medic	16	DELORES		G	RAHAM		04 17	ay Year	12.49 PM
Examin	Sec.	4a. Facility Name (If not institution, give				Location of Death	4	c. County of Death	
		400D SAMAR	ITAN HOSPI			IMORE		N	14
Funeral Director		216-36-8567	Sex 7. Age (In yr:	s. last birthday,	Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea VOV, O6, /	9. Birth Cook	place (State or Foreign intry) RI/LAND
and		Usual Residence of Decedent 10a, State 10b, County	10c. (City, Town or L	ocation		/		10d, Inside City Limits
Maryl f sho	lor	MADULALA A	1/2	,,	Bal	TIMORE	CIT	/	1 Yes 2 No
r death with the Maryland teme 23a or 28a-f show at must be rediffed at	Director	10e. Street and Number	11-1	i	10f. Zip Code	.11702		Citizen of What Cou	untry?
23a ol		2303 PEN	TI AND DE	ADT 21	2	2123	4	115	A
er deatl iteme 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi	ispanic Origin? (Speci n, Mexican, Puerto Ri	ly Yes or No-	14. Race - Amer	
aff F	F	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		1 ☐ Yes 2 No	Specify:	can, etc.)	Black, White	, etc.
hours ture!',	d by	3 Widowed 4 □ Divorced	Year or Dates:					Specify: BL	ACK
72 in a	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupa kind of work done	during most of working	16b.	Kind of Business/I	ndustry
within ene. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	MA	DO NOT use retired	() Area	Tap 111	100000	ART CUPCO.
filed Hygir other	e C	17. Father's Name (First, Middle, Last		///	CHINE	18. Mother's Name (First, Middle, Maide		ARI CUPCO.
d be ental kad c	To B	MILTON	C H	ANCE		THEIN	11	MA	ILER
shou nd M mar	Н	19a. Informant's Name/Relationship (ng Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Zi	Code)
permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene (Important: If Item 27 is marked other than "1 mportant or other traumatic event, It a Mad one.		ZAKIVVA PATTE	RSON GRAND-DAUG	3) 23	03 PEN	TLAND B	P. APT 20	2 BALTO	MO 21234
of He of He roth		20a. Method of Disposition)	Place of Dispo	osition (Name of matory or other place	e) Dat	e 20c.	Location - City or T	own, State
nit. Page partment ortant: If injury o		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		INGA	IEM PAR	11 04-21	-06 W	OONIAN	W. MD
permit. Departr Importu any inji		21. Signature Funeral Service Lice		the second second second second	2. Name and Addres	ss of Facility BRO	WALTR.	FUNER	AL ITOME
20729		X SU	wna	2	2178 N.	FULTONA	VE, BAL	TO. HO	21217
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not en	Λ				Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. ASPIK	A 716	NPI	NEUMOI	VIA		Onset and Death
/Medical Examiner		Tesulting in death)	Due to (or as a conse	equence of):					
	-	Sequentially list conditions,	b. Due to (or as a conse	equence of					
acuted ind transit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		.,					
	Exa	that initiated events resulting in death) Last	c. Due to (or as a conse	equence of):					-
icate be exe physicien ar s the burial-t			d.						
tifical	ledi	V-2-2-							
The law requires that the death certificate be exate has been signed by the attending physicien page 2 should be detached for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr		DEctopic pregnancy			23d. Date of deliv	.,
e dea he att	slci	in the past 12 months? 1 🗆 Yes 2 🐼 No	4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year
at the	Phy	9 Unknown							
ires the signe	þ	Part II. Other significant conditions			,				the cause of death? bably 4, \(\square \square \text{Unknown} \)
: The law require cate has been sig , page 2 should b	Completed	DIABETES MEL	citos, caron	VHAY	MKIEKY	DISEMSE	1 🗆 Yes	2 □ No 3 □ Pro	babiy 4 Onknown
e law has t	npi	HYPERTENSIO					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
iclan: Th certificate rector, pag		MYESTHENIA !	GRAVIS, 4A	STROP	PARESIS	<u> </u>	performed? 1 ☐ Yes 24 ☐ N		2 🗆 No
siclar	Be	examiner?				26. Place of Death (
	2	1 Yes 2 No	Hospital: Inpatient 2 [28b. Time o	f 28c. Injury	at 28	5 Residence Describe how in		fy)
th. Afte	ertification:	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	t? Yes 2 □ No		,	
Atter r dea ector by the	HC	3 Suicide 6 Could not b	289. Place of injury - At	home, farm, st	reet, factory, office	28		and Number or Rur	al Route Number,
s afte	Cert	4 Hornicide	building, etc. (Spec	эну)			City or Town, Sta	<i>(θ)</i>	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical	29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kr miner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	ne, date and place, and pinion, death occurred	due to the cause(at the time, date a	s) and manner as and place, and due to	stated. o the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier		T	29c. License			ate signed (Month,	
		M. Xam	\sim M_{\odot}	D	KES	5 000	0.	4-17-2	006
1		30. Name and address of person who NIVE DITA PANT	completed cause of death (Ite	эт 23a) (Туре, ОСН К				MARYLAN	ID-21239

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

APR 1 9 2006

32. Registrar's Signature

		-	For State Registrer	State of M	arylan		artment of rtificate of		Mental Hy	giene Reg. Na	11111	12218
	<u>#</u>		Decedent's Name (First, Middle, L.	ast)					2. Date of D			3. Time of Death
	Physicia /Medic		Betty A. G	oodman					April			1:10 P M
()	Examin		4a. Facility Name (If not institution, g)		4b. City, Town,	or Location of Dea	ath	40	c. County of De	
			Greater Baltimo					owson			Baltim	
	Funeral		,	Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. i 83	last birthday, Yrs.	Months Days			irth Pa <i>y, Year</i> I 2 1 0	9. E	Birthplace (State or Foreign Country) ermany
	Director	-	217-14-6957 Usual Residence of Decedent		- 05				INOV.	3,13	722 0	-
	ryland how		10a. State 10b. County		10c. City	y, Town or L	ocation					10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f ehow rmast be notified at	Director	Maryland			Balti	more Cit	У		T		1 ☐Xes 2 ☐ No
	ior 2	Dire	10e. Street and Number				10f. Zip Code				itizen of What	
	s 23s	ra	4005 N. Charles S	treet	Ever in II	S 13	Was Decedent of		Specify Yes or N		ted Sta	ates merican Indian,
	ter de	Funeral	11. Marital Status1 ☐ Never Married 2 ☐ Married	Armed Forces	?	.5.		Hispanic Origin? ban, Mexican, Pue	erto Rican, etc.)		Black, W	hite, etc.
036	e filed within 72 hours after death with the Marylan at Hygiene. other then "natural", or items 23e or 28e-f show vent, its Medical Examiner must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	-		1 ☐ Yes 2 🔀 N	o Specify:			Specify: V	White
9	72 hc	Completed	15. Decedent's (Specify only highest g			(Give	edent's Usual Occi e kind of work don	e during most of w	orking	16b. I	Kind of Busine	ss/Industry
\$ 4	vithin ne. hen	mp	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retir	,			Orm Hon	no.
25	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, La	4st)		l	Homemake		ame (First, Midd		Own Hor	ile
SCOMAN (BE)	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 ie marked other then other traumatic event, the Me	To Be	Charles Russe					Acr	nes Gu	nthe	r	
√	shou ind M mar	۲	19a. Informant's Name/Relationship			19b. Mail	ing Address (Stree	et and Number or		ber, City	or Town, State	e, Zip Code)
Z Ž	and 2 alth a 127 i		Charles R. Goodn	nan , Son		602	Valley L	ane, Tow		2128	6	<u> </u>
) Sre	of He fiterr		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Bemoval from State	. 0	emetery, cre	osition (Name of ematory or other p		Date			or Town, State
S F	Pag ment ant: i		4 ☐ Donation 5 ☐ Other (Spe	gify)	Dul			Cardens 4/		_	nium, Ma	
SCCOMMON BELLEN Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		21. Signature of Fune at Service Life	ensee M	M0111	3 D	22. Name and Add ulaney Val	ley, P.A.	rian T. Ch 200 Padon	isholi ia Ro	m Funera ad, Timo	l Services of nium, MD 21093
		. 1	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ty one cause on each	d the deat	h. Do not er	nter the mode of d	ying, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Pheur	monio	a						weeks
	/Medical Examiner		resulting in death)	Due to (or a								months
		-	Sequentially list conditions,	b. Lung								VVCC VCT VCS
16	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
4	exection and rial-tra	Exa	resulting in death) Last	Due to (or a	s a conseq	uence of):						
8760,	Attending Physician: The law requires that the death certificate be executed r death. cross. After this certificete has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Ical		d								
9	e as (Med	IF FEMALE:	00- 14								
Division of Vital Records, P.O. Box	eath certific attending p I for use as I	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Feta	death 3	☐Ectopic pregnar				23d. Date of Month	delivery Day Year
o.	t the de by the a tached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	at time or c	Jean 3	Other (specify)					
م ِ	that hed by deta	by Ph	Part II. Other significant conditions	s contributing to death	but not res	ulting in the	underlying cause	given in Part I.	23e. Die	tobacco	use contribut	e to the cause of death?
rds	w requires been sign should be								- 10	Yes	2 □ No 3 □	Probably 4 Unknown
<u>ွ</u>	aw re	piet	70						24a. Wi	as an topsy	24b. Were	autopsy findings available to completion of cause of
Ä	The lav	Completed							pe 1 ☐ Yes	rformed2	death	1?
/ita	sician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?						eath (Check onl			
of C	Physic this o	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat		ER/Outpatie		Other: 4 Nursing			6 □Other (S	Specify)
u C	ding F h. After funera	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigat	28a. Date of In (Month, D	ay Year)	Injury	W	ork? ☐ Yes 2 ☐ No	200. Describ	e now m	jury occurred	
isi	Attendideath.	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of li	njury - At h	ome, farm, s	street, factory, offic		28f. Location	(Street a	and Number of	Rural Route Number,
Ο̈́	al or / s after of Dire	Certification:	4 ☐ Homicide	building, e	etc. (Specil	fy)			City or I	own, Sta	170)	
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical		Physician: To the best maminer: On the basis and manners	of examina							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	6 0				ense number				onth, Day, Year)
			Rations	J Keni	u Tho	mas, A	VID	D60630			4/18/00	ś
	10		30. Name and address of person with Rem Two Nas, N	ND 6701	N. 00	naries	St. Tow	vsun, N	ID 2120	4		
*	Sta Regist		31. Date filed (Month, Day, Year)	9 2.006 32. Re66s	strar's Sign	ature	fords.					

			•	1- State of Mail Registrar	-	epartment of F Certificate of I		ental Hygie Reg.	4. U U 0	12219
		Dhysioi	20	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yeer	3. Time of Death
		Physicia /Medic		Judith Ann Grob		4. 65. 7	r Location of Death	April 14,	2006 Year	9:15 A M
		Examin	er	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical	Center	Bel A	_		Harford	,
AM		Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day, Ye Jan. 24,	9. Birth	nplace (State or Foreign untry) YLand
K		Director		216-36-4947 1 M 243 F Usual Residence of Decedent	65 Y	rs.		Jan. 24,	1941 Mai	ryland
5		/land			10c. City, Town	or Location				10d. Inside City Limits
5		e Man	ctor	Maryland Harford	Edgewoo	d				1 ☐ Yes 2 No
0		within 72 hours after death with the Maryland ane. than "naturel", or Iteme 23e or 28e-f ehow he Medical Examinat must be notified at	by Funeral Director	10e. Street and Number 1225 Chipper Drive		10f. Zip Code 21040		10g. US	Citizen of What Co	untry?
		ne 236	eral	11 Marital Status 12. Was Decedent Ev	ver in U.S.	13. Was Decedent of H	lispanic Origin? (Spec		14. Race - Amer	ican Indian,
	9	or iten	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give		If Yes, specify Cuba	an, Mexican, Puerto R Specify:	ican, etc.)	Bfack, White	VI.
	21215-0036	urel',	d by	3 Widowed 4 Divorced Year or Dates:	1.40			Lan	Specify:	White
	15	in 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of working d)	9	o. Kind of Business/I	ndustry
	212	d with giene.	omi	Elementary/Secondary (0-12) College (1-4or 5+		munications	Technicia	an Me	edical	
. 0		be filed within 72 hatal Hygiene. Id other than "natuevent, the Medical	Be	17. Father's Name (First, Middle, Last) James Gilbert Dailey			18. Mother's Name	(First, Middle, Mai Cecilia		
0	Maryland	Me Me	ို	19a. Informant's Name/Relationship (Type, Print)	19b	Mailing Address (Street				in Code)
E	≥	nd 2 lith a 27 ie r trai	1	William Grob / Husband	12	25 Chipper	Drive, Edg	gewood, N	D 21040	
7(14/00	ore,			20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ Removal from State	20b. Place of cemetery	Disposition (Name of crematory or other place	Da	ate 200	c. Location - City or	Town, State
4	Baltimore	mit. Pages bartment of I bortant: If Its r injury or o		4 □Donation 5 □ Other (Specify)	Hillto	p Service C			wson, Mar	yland
	Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	t	McComas Fu 1317 Cokes	inefally Home sbury Road	e, P.A. , Abingdo	on, Maryla	and 21009
				23a. Part1. Enter(the disease, or complications that caused shock, or heart-ailure. List only one cause on each line	death. Do n	ot enter the mode of dyir	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
		Physician		fmmediate Cause (Final disease or condition resulting in death)	opened	·				- 2-3, len
		/Medical Examiner		Due to (or as a	consequence o	f):				~ 2-3.0
00			Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence o	f):				
10	4	cate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events c.	tatic ?	De Deme	le con	we _		~ 6-7 ym
4)	60,	be exe icien a burial-		Due to (or as a	consequence o	r):				
_	68760	ficate physics the l	edicai	d						
	Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth		3 Ectopic pregnance	v		23d. Date of deli	,
	О. В	e death the atte	slcle	in the past 12 months? 1 Yes 2 No 9 Unknown		5 Other (specify)	,		Month	Day Year
	P.O.	res that the dei igned by the a be detached f	/Ph	Part II. Other significant conditions contributing to death but	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute to	the cause of death?
2	Records,	quires in sign	ed by	- Anemia				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Onknown
0,09	ဝ၁	e law requir has been si je 2 should	Completed	- New Neck Comes	/			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
9		hysician: The Is his certificate ha I director, page 2	Com	- Enoline history				performed	d? death? 1 ☐ Yes	
_	Vital	sician certifi rector	Be	25. Was case referred to medicat examiner? 1 Yes 2 Hospital: 1 Inpatier	nt 2 ER/Out	Ott	26. Place of Death		- a = 0.	
7	of	g Physer this eral di	n: To	27. Manner of Death 28a. Date of Injury		ime of 28c. Injur	4 Nursing Hom	8d. Describe how	e 6 ⊡Other (Speci injury occurred	iny)
1	ion	anding Fath. or: After	atlo	2 Accident investigation	rear) ir		Yes 2 □No			
FIPO	Division	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 Suicide 6 Could not be determined 28e. Place of Inju.	ry - At home, far . (Specify)	m, street, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
1	_	pspital hours uneral y filled		29a. Certifier 12 Certifying Physician: To the best o	f my knowledge	death occurred at the ti	me, date and place, a	nd due to the caus	se(s) and manner as	stated.
		To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exeminer: On the basis of and manner state	ed.	29c. Licens			. Date signed (Mont)	
		To To	-	29b. Signature and title of Sertifier	1	MD 7	2500L6	290.	04 - 14	
		h		30. Name and address of person who completed cause of de	path (Item 23a) (Type, Print)	1	M	2/0/0	
		<i>V</i>	ate	31. Date filed (Month, Day, Year) . Registra	r's Signature	10 L, Ed.	genord,	11)	1040	
		Regist		APR 1 9 2006 Leave	J. A	recke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 4:35 PM April 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 00 Bultimore Baltimore Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral M** 2□ F 3 Director sual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo 10e. Street and Number 10f. 10g. Citizen of What Country? 20 and Mental Hygiene. Is marked other than "natural", or itams 23a Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian 11. Marital Status Forces? s 2 ☐ No Black, White, etc. es l WNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, permit. Pages 1 and 2 should be fill Oppartnent of Health and Mental Himportant: If Item 27 is marked oth any injury or other traumatic even QUCS. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip I OF WINSTI 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Approximate Interval Between Onsettand Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DEPSIS Doyc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No 1. Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death Certification; Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funaral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1º Certifying Physician: To the best of my knowledge, death occurred at the time, data and due to the nausa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number KES-000 April 11, 2006 00 30. Name and an iress of person who completed cause of death (Item 23a) (Type, Print) Hospital of 32 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 19

Marshall Howell

takent known

Amend Item 19a per F.H G-854 4/19/06 reb Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For	State of Maryla		epartment of F		, ,	2 U U b	12221
			Registrar 1. Decedent's Name (First, Middle, La	st)		crinicale of	Dealii	2. Date of Deat	eg. No.	3. Time of Death
	Physici /Medic		Panela	Delores		Hort	07	April	Day Year	
	Examir	er	4a. Facility Name (If not institution, giv The Johns Hopkins			4b. City, Town, or Baltin	r Location of Death	4	4c. County of Dea	th 4
	Funeral Director		5. Social Security Number 6. S 218 (00 . 44-79	ex 7. Age (In y	rs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town o	r Location		1-1		10d. Inside City Limits
	e Mary Be-f eh	ctor	MD N/A	<i>t</i>	Bat	imore				1≱Yes 2□No
	th with the 23a or 29	Funeral Director	1245 Sheridan	Avenue		10f. Zip Code	239	1	0g. Citizen of What Co	ountry?
020	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or Iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	ρ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	n U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: 2	
ה ה	in 72 h "natu Policel	oletec	15. Decedent's Ed (Specify only highest gra	ide completed)	(6	ecedent's Usual Occup five kind of work done of te. DO NOT use retired	during most of work	king	16b. Kind of Business	·
7 7	led with ygiene. ner that	Completed	Elementary/Secondary (0-12)	5+ Years		Teach			Baltimo	re City
700	Mental H Mental H arked oti	To Be	17. Father's Name (First, Middle, Last) Mack Horton					ne (First, Middle, M		
Mar	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other than 'eny injury or other treumatic event, the Means injury or other treumatic event, the Means		19a. Informant's Name/Relationship (Type, Print) Brother	19b. M	ailing Address (Street a	AVENUE		City or Town, State, .	
บั 	ages 1 a nt of He t: If item y or othe		20a. Method o Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State		sposition (Name of crematory or other place	e)	,	20c. Location - City or	
	permit. P Depertme Importen eny injur:		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	·	Ring	32. Name and Address	ss of Facility rene Fund Road Ball	21/06 and Service	es	town, MD
	402.4		23a. Part1. Enter the disease, or com	plications that caused the d	eath. Do not					Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)			enal Disea	ise			Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. Due to (or as a cons	sequence of):					
	ocuted nd transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
500	icate be executed physicien end s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
9	tificat og phy as th	60								
C. DOY	The law requires thet the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	ivery Day Year
50	w requires that been signed by should be deta	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in th	e underlying cause give	en in Part I.		acco use contribute to	1/
5	requ been shoulk	etec								
	The law sete has page 2:	Completed	•					24a. Was au autops perform 1 ☐ Yes 2	24b. Were au prior to death?	utopsy findings available completion of cause of
	Jing Physicien: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Uitali				h (Check only on	9)	
5	Physic this aldir	ဥ	1 ☐ Yes 2 🔀 No 27. Manner of Death	Hospital: Impatient 2	ER/Outpa		4 Nursing Ho		nce 6 Other (Spe	cify)
	tending F leath. tor: After the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year	28b. Tim Inju	ry Worl	yat ⟨? Yes 2 □ No	28d. Describe ho		
5	tel or Atrice after del Direct	Certifi	4 Homicide determined	building, etc. (Spe	ecify)			City or Town		
	To the Hoepitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certifica completely filled in by the funeral director, I	edicai	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, d ination and/o	eath occurred at the tim r investigation, in my op	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the vithing complete comple	M	29b. Signature and title of certifier	Klini	m	29c. License			PRIL IV.	
	10		30. Name and address of person who	completed cause of tleath (tem 23a) (Ty		, 0.	10	0 MM 2	2006 1287-9106
	: U	10	31-Date filed (Medith, Day, Year)	OCO Noy	th M	olfe stre	et 12A	ulimor	ار ا	2017100
	Sta Registr	ar	APR 1 9 2006	Blown &	Spoon	E)				
DH	MH 17 Rev 1/20	001		-	6					

06-02595 Claude Hicks

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate of Death	Re	eg No	2006	1 6 6 6
Physiciar Medical Examin	4	1. Decedent's Name (First, Middle, Last) CLAUDE LEWIS HICKS, SR.	2. Date of Dea Month April 16, 2	Day	Year	3. Time of Death 2332 hrs
		4a. Facility Name (if not institution, give street and number) University of Maryland 4b. City, Town, or Location of Dea Baltimore	ath	4c. (County of Death	
Funeral Director		213=30=3139 1XM 2 F 53 Yrs.	lin. 8. Date of Bir 02/1	,	Foreig	thplace (State or gn 中教女LAND
w any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at onee.	ġ.	MD N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code	Ta	On Citina		1 XYes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Il Director	3806 PENHURST AVENUE 21215		USA	n of What Cou	ntry?
er death wi	Funeral	11. Marital Status 1 Never Married 2 X Married 1			White, etc.	can Indian, Black,
ours aft	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the completed)			nd of Business/	
Z	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS College (1-4 or 5+) AUTOMECHANIC/STEEL		AU ST	TOMOTI EEL IN	VE & IDUSTRY
		T1 WEG 1 WEGWG 05	me (First, Middle, M		,	
2121 2121 ould be fill Mental I marked ic event,	o Be	JAMES A. HICKS, SR. 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of S	DOLYN C			, Zip Code)
e, MD I and 2 sho Health and item 27 is	1	PATRICIA D. CAMPBELL/SISTER 3806 PENHURST A	VENUE,	BAL	TIMORE	21215 MD
	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ecation - City or	
[6 를 열 요 골.	+	4 Donation 5 Other Specify: MT. ZION CEMETERY 4 21. Signature of Funeral Service Lice is 22. Name and Address of Facility 11	/22/06	LA	NSDOWN	E, MD
Balt permit Departi Importi		When I O' TWW 4600 LIBERTY H	EIGHTS	AVE	, BALI	'IMORE, MD
Physician /Medical		234 Fart. Enter Medisease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac failure. Listonly one cause on each line. Brain infarct complicating hypertensive	or respiratory arre	est, shock lerot:	k, or heart iC	Approximate Interval Between Onset and
xaminer		Infimediate Cause (Final disease of condition resulting in death) a. <u>cardiovascular disease</u> Due to (or as a consequence of):				Death
· e	Ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
cuted and transit		events resulting in death) Last Due to (or as a consequence of).			_	
ficate be executed ficate be executed g physician and s the burial - trans	edica	X UNPENDED AMENDED item#23a,PII,27,perME,g855,5/10/06	TT			
8760 tificate b	<u>ا</u> ج	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nancy		Date of delivery	
that the death certified by the attending detached for use as	Physicial	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown				
ires that the signed by		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus		_		the cause of death?
ords, l	Completed by	Dianetes Perritus	24a. Was a			topsy findings available
e law r te has b	dw			med?	prior to death?	ompletion of cause of
tal Reco	ادہ	25. Was case referred to medical 26.Place of Death (Chec	1 Yes :	2 N o	1 🗸 Ye	s 2 No
of Vitaing Physiciang Physiciang After this connerted directions	0 0	100 2 100		Residenc		:
C =	ation:	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d Describe h	now injury	occurred	
Divisior Hospital or Attend 24 hours after death 25 thours Director: tely filled in by the	Certification:	Suicide 6 Could not be determined Could not be determined Could not be determined Could not be determined Could not be determined Specify)	28f. Location (S or Town, S		Number or Ru	ral Route Number, City
a - = >	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, are one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.			ite signed (Moi	nth, Day, Year)
	-	30. Name and address of person who completed cause of death (Item 23a)	1	April	17, 2006 	
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01			
Sta Pegistr	_	31. Date filed (Month, Day, Year) APR 1 9 2006				

ORIGINAL

			1 - For State Registrar	State of M		d / Depa		t of H	ealth a	and M		giene Reg. No.) 6	222	3
	Physici		1. Decedent's Name <i>(First, Middle, L</i> a Margaret V		٦d						2. Date of Dea Month April	Day 17	2006	3. Time of 7:46	Death a M
	/Medic Examin		4a. Fecility Name (If not institution, giv Edenwald	e street and numbe	r)		Tows	on	Location of	of Death		Ba	unty of Death A I timor	`e	
	Funeral Director		5. Social Security Number 215-50-4535 Usuel Residence of Decedent	Sex 7. A I□M 2XIF	102	last birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt Month, Da OCt. 3	, 190 190	9. Births Caur V1 Y	place (State o	r Foreign
	Maryland If show	tor	10a. State 10b. County Md. Baltim	ore	_	y, Town or Lo	ocation						1	0d. Inside Cit	
	th with the 23s or 28s	al Direc	10e. Street and Number 800 Southerly Rd	•			10f. Zip	Code 2120	4			10g. Citizen	of What Cour	ntry?	
. 980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any njury or other treumatic event, the Medical Examinating must be notified at ance.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates	s?] No	1	Was Deced If Yes, spec		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify:		
Maryland 21215-0036	d within 72 hogiene. sr than "natu	ompieted	15. Decedent's E (Specify only highest gr.		r 5+)	16a. Dece (Give life. Homem	dent's Usua kind of wor DO NOT us aker	al Occupa rk done d se retired	ation during mosi i)	t of worki	ing		of Business/In	dustry	
yland ;	ould be filed Mental Hyg arked othe	To Be C	17. Father's Name (First, Middle, Last William F. Zimm						Elea	nor	Griffi Griffi	th			
	and 2 sho saith and n 27 is m		Mrs. Myrtle Walke			8810	Walt	her		#10	al Route Numbe 105 Park	ville	, Md. 2	21234	
Baltimore,	Pages 1 ment of He ent: If Iter ury or oth		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci	(y)		Place of Dispo cemetery, crea uid Ri	dge C	ther plac emet	ery	4-20		Pikes	on - City or To SVille,		
Balt	permit. Depart Import any inj		21. Signature of Funery Service Lice	75×	<u> </u>	22	2. Name an Ruc 105	d Addres k To O Yo	s of Facilit WSON rk_Rd	Fune L. To	ral Hom wson, M	ne, Ind ld. 212	<u>204</u>		
	Physician		23a. Part1. Enter the disease for come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.									Approximate Interval Bety Onset and D	ween Death
68760,	Medical Examiner hysician and the prinal-transit	icai Examiner	Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. One to (or a Due to (or a d.			n	(1)	DL ins	15	mil mo	106	noscu	20 m	Yng
.O. Box 68	ath certific ittending p or use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Il death 3	Ectopic pr		,,,,,	***		23d.	Date of delive Month		'ear
S, D	requires that the de teen signed by the a hould be detached f	by	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	1	contribute to the	ne cause of do	
I Record	The law ate has b page 2 s	Completed									24a. Was autop perfo 1 Yes	sv	death?	psy findings a mpletion of ca 2 \(\text{No} \)	available ause of
Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2	ER/Outpatier	nt 3 DC	A Othe	T. 19	2000	n <i>(Check only o</i> me 5 ☐ Resid		Other (Specif	v)	
ion of	ding h. After fune		27. Manner of Death 12. Natural 5 Pending 2 Accident investigation	28a. Date of in (Month, I		28b. Time o Injury		8c. Injury Work			28d. Describe h			,	
Division	i di di	Certification:	3 Suicide 6 Could not be determined	289. Place of I	njury - At h etc. <i>(Specil</i>	ome, farm, st	reet, factory	r, office			28f. Location (S City or Tox		umber or Rura	i Route Numl	ber,
	To the Hospital within 24 hours a vithin 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical Exa	nysician: To the bearings: On the basis and manner	of examina		vestigation,	, in my of	oinion, dea		ed at the time,	date and pla	ce, and due to	the cause(s))
)	with	Σ	29b. Signature and title of certifier	lun	_				7 8	3 8			gned (Month,		200
5	7		30. Name and address of person who	ATH L	- 0	CIC	Print)	00	カハか	774	ROAL) : 41	NITTE	1021	290
	Sta Registi		31. Date filed (Month, APR 1 9	2006 32/R/6jis	strar's Signa	ature	beck	,				<i>,</i>			7

			1 – For State Registrar	State of Ma		l / Depa		t of H	ealth and	d Mental H				222	errenned a
	Physic /Medi		1. Decedent's Name (First, Middle, Las Amelia Lore		ller					2. Date of I Month APRIL		ay	Year OO Co	3. Time of D 12:05	eath
	Exami		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of De			c. County			
			7905 Kavanagh Ro		(In um In	nt himbdaul	If Under		ndalk If Under 24 F	lee a D		Ва		re Co.	
	Funeral Director		205-26-1733	M 25kF 74	(in yrs. ia:	st birthday) Yrs.	Months	Days		in. 8. Date of the sept.	Day, Yea	r) .931	9. Birthpl Coun Penn	ace <i>(State or i</i> try) yslvan:	Foreig ia
rland	Mo		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10	Od. Inside City	Limit
the Man	28e-1 sh	by Funeral Director	Maryland Baltin	more			10f. Zip	Codo	Dund	alk	10- 6	itizen of W	/h O	1 ☐ Yes 2	! (3 0)
With	3e or	0	7905 Kavanagh I	Road			101. 210	212	222			ted s		•	
deat	ems 2	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	. 13.	Was Deced			(Specify Yes or I		14. Race	- America	an Indian,	
ours after	ral', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			r Yes, spec 1 ☐ Yes 2			епо нісал, etc.)		Specify	k, White, e	hite	
d Z I Z I J-0030 filed within 72 hours after death with the Maryland	f Health and Mental Hygiene. item 27 ie marked other then "natural", or items 23e or 28e-f show other treumatic event, II a Medical Evaniner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	,	16a. Deced (Give life. I	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired,	tion uring most of s	working	16b.	Kind of Bu	siness/Ind	ustry	_
- M	Hygiene. other then ent, the M	Con	12 Years			Hon	emake	r				Own	n Hom	e	
pe I	d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's N	lame (First, Midd	le, Maide	n Sumam	9)		
pluor	and Mental I le marked of eumatic eve	2	John Mascovitch							ry Sterk					
g	Health and tem 27 le nother treun		19a. Informant's Name/Relationship (T) Timothy Heller (S)			7905	Kavar	agh		Rurai Route Num Dundalk,				Code) 222	
	Department of Healmportent: If item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		cen	ce of Dispo netery, cren top S	natory or ot	her place	1	Date 15/2006		ocation - o		vn, State yland	
permit.	Department of H Importent: If ite any injury or ot once.		21. Sign and of Funeral Service Licens	7		22 D	Name and	d Addres UCK	of Facility Funera	1 Home o	f Du	ndalk	, In	_	
1	Medical xaminer the prize	Ilcai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a document). Due to (or as a document). Due to (or as a document).	conseque	nce of):	IE PUI	Mor	JARY T	DISEASE				Interval Betwe Onset and Dei	ath
the death certific	ned by the attending ph detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal de	eath 3	Ectopic pre Other (spe					23d. Date Mon		y Day Yea	ır
law requires that the	been signed t	by	Part II. Other significant conditions con	ntributing to death but	not resulti	ng in the ur	derlying ca	use give	n in Part I.		.1	_		cause of deal	
sicien: The law requires t	has ye 2	Completed	OSTEOPOROSIS								opsy	pr	ior to com	sy findings ava pletion of caus	ulabl
en: The	certificate ha rector, page	e Co	CORDNARY ARTO	SRY DIS	EASC	5			OR Place of D	1 ☐ Yes	ormed?	1 1	eath? Yes 2	□ No Son's	
Attending Physicien:	After this funeral di	ation: To B	examiner?	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28	NOutpatient Bb. Time of Injury		c. Injury Work	4 Nursing	Home 5 Res	idence			Reside	-
	s after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home (Specify)	e, farm, stre	et, factory,	office		28f. Location City or To			or Rural i	Route Number	:
To the Hospitel or	within 24 hours after d To the Funeral Direct completely filled in by	edicai	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of a ner: On the basis of ea and manner state	xamınatıor	edge, death n and/or inv	occurred a estigation,	t the time in my opi	, date and pla nion, death oc	ce, and due to the curred at the time	cause(s , date an) and man d place, ar	ner as stat nd due to t	led. he cause(s)	
Tot	within 2 To the I complet	×	29b. Signature and title of certifier	1			29c.	License	number		29d. Da	ite signed	(Month, Da	ay, Year)	
, i*			30. Name an address of person who co	mpi ed cause of dear	th (Item 2)	3a) (Tyna F	2-1-12		032		APP		(1	2006	
4	Sta Registr	20	JEANTER HAYASH 31. Date filed (Month, Day, Year)	4(', 5505 32. Registrar's	HOPK s Signatur	115	BAYVII	SW.	CIRCLE	, Bacti	NORY	E M	D 2	21224	

			State of Maryland / I			•	_	
		_	1 - State Registrar	Certificate of	Death	Reg.	7 H H fs = 1	12225
	Physicia		1. Decedent's Name (First, Middle, Last) Josephine C. Hensley			Date of Death Offil 16,	Da 2006 Year	3. Time of Death 1:30 AM M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)		or Location of Death		4c. County of Deat	h
			Johns Hopkins Bayview Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bit	Baltimon		Date of Birth	N/A	hplace (State or Foreign
	Funeral Director		217–38–8700 1□M 2 3 F 66	Yrs. Months Days	Hours Min. J	(Month, Day, Yeuly 14,1	939 Mary	/Iand
phand	Mow	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Location				10d. Inside City Limits
N C	Ba-f e	ctor	Maryland N/A Baltim	ore				1 Yes 2 No
death with the Maryland	3a or 2 d be no	Funeral Director	10e. Street and Number 4902 E. Chase Street	10f. Zip Code 21205		_	Citizen of What Co	-
T death	eme 2	ınera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H	dispanic Origin? (Speciforan, Mexican, Puerto Ric	y Yes or No-	14. Race - Ame Black, White	
5-0030	"natural", or iteme 23a or 28a-f ehow	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No	Specify:		Specify: [M]	nite
0-C	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occup (Give kind of work done life. DO NDT use retire	pation during most of working	168	o. Kind of Business/	Industry
7 1 7 1 X	r than	ошо	Elementary/Secondary (0-12) Cottege (1-4or 5+)	memaker	3)		Oomestic	
yrang 2	e d a	Be	17. Father's Name (First, Middle, Last) Thomas Robinson		18. Mother's Name (F			
Schould	and Me ie mark aumatik	ဥ	19a. Informant's Name/Relationship (Type, Print) 19th	b. Mailing Address (Street			•	
e, 5	f Health Item 27 other tr		20a Method of Disposition 20b. Place of	02 E. Chase of Disposition (Name of	Date		Maryland Location - City or	
	ment of ant: If It ury or o		Parisis 2 Compation 3 Permayal from State Cemete	ary, crematory or other pla- awn Cemeters	04/20/2		timore, N	
Balt	Department of Piper Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Licensee Warish & Walter		ester Stree			
			23a. Part1. Enter the disease of complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final	not enter the mode of dyin	ng, such as cardiac or re	aspiratory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death) Due to (or as a consequence	1/ycemac	•			hours
* =	xaminer	_	Sequentially list conditions, b. Due to (or the property of th	hypostyc	icmic M	coli(a	dion	days
patit	ansit	Examlner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as a consequence b. Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events c.	5 DM WIN	A proteir	mia	-	year
be executed		al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence	of):				
Y D X (ng phys		d.					
ם פּ	0 0	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 ⊟Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of deli Month	ivery Day Year
ecords, P.O.	been signed by should be deta	by	Part II. Dther significant conditions contributing to death but not resulting if Hypertension, asnal fibrilla	in the underlying cause given the form of	ven in Part L	23e. Did tobac	1	the cause of death?
1 4	ete has page 2	Completed	perigheral vas culor de	widin,		24a. Was an autopsy performed	prior to death?	topsy findings available comptetion of cause of
VITAL	certific rector,	Be	25. Was case referred to medical examiner?	Ott	26. Place of Death (C			
0 4	er this	n: To	27. Manner of Death 28a. Date of Injury 28b.	Time of 28c. Injur	4 Nursing Home	5 Residence 1. Describe how i	e 6 ⊡Other <i>(Spe</i> d injury occurred	cify)
DIVISION OF VITA	death. ctor: After y the funer	catlo	2 Accident investigation	M 1	Yes 2 □No			
5 8		Certlfication:	4 Homicide determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f	. Location (Stree City or Town, S	it and Number or Ru Itate)	ıral Route Number,
Jetinoch edt		Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination and manner stated.	ie, death occurred at the til nd/or investigation, in my o	me, date and place, and opinion, death occurred	I due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
L L	within To the comple	Ž	29b. Signature and title of certifier P. Cutter row	-	27220	4	Date signed (Monti	h, Day, Year)
3	1		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 4924 (G-	mptell s	3/10,	Baldin	10 K, 21236
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2006 APR 1 9 2006	ale				
		204						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 13 04 **ZO**06 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BONSOCOUR Baltimore N/A f Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) May 5, 1939 **Funeral** 9. Birthplace (State or Foreign Sex Y 1□M 2⊡F Months Days Hours Min 213-36-6195 Washington Director 66 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County r than "natural", or itame 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 ☐ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 South Pulaski St. 21223 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) te marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 6 Homemaker Own Home filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Cecil Skaggs Nolva Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if Itam 27 te any injury or other traignes. William A. Holthause, Jr. 406 S. Pulaski St. Baltimore, MD. / husband 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 □ Burial 2 ☐ Cremation 3 □ Removal from State West Arundel Crematory 04-19-06 Odenton, MD 4 □ Donation 5 □ Qther (Specify) 21. Signature of Funeral Service License ²² Name and Address of Facility. Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only appears on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit DWOW ID physicien s the burial Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) signed by the a Id be detached f o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗆 Yes 2 🗆 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe med? 2 € No Division of Vital 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Matural 5 Pending Injury within 24 hours after death.

To the Funeral Director: All completely filled in by the fu М investigation 1 ☐Yes 2 ☐No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

			Please Type or Print in Black indelible ink. Ensure Al	-	_	Die.
			State of Maryland / Department of Health and M	ientai Hyg	jiene	10007
			Registrar Certificate of Death		eg. No. U	0 12261
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Dea Month	th Day	Year 3. Time of Death
	/Medic		Chase I lichael Hurst	Apr	11	OG 10:13 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	•	4c. County	of Death
			Harbor Hospital Center Daltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		MIA Yrs. 36	4 11	06	Cm.
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location			404 (114-02-11-2
	aryla shov	٠.	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f-	ct	MD 12 Himore Beltimore			1 1 1 1 4 5 2 5 5 0 0
	ih th or 21	-i-	10e. Street and Number.	1	log. Citizen of V	What Country?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "naturel", or items 23a or 28a-f ehow event, the Medical Examinal must be notified a	Funeral Director	4750 Drayton Green 21227		Uni	ted States
	ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rao	e - American Indian, k, White, etc.
0	or it	F	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	,	Specify	1 1 6
0000	within 72 hours after ene. than "naturel", or Ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Зреспу	White
ก็	72 h natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	ina	16b. Kind of Bu	usiness/Industry
7	thin	du	Elementary/Secondary (0-12) College (1-4or 5+)			
7	filed with Hygiene. other tha	Co	Intant Intant		-Lr	tant
and	be filt stal Hy od oth even	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, I	Maiden Sumam	18)
<u>a</u>	should be nd Mental marked o	2	William Youl Hurst SAndr	a L	55 _	Tipton
	2 should be and Mental Is marked sumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	il Route Number	r, City or Town,	State, Zip Code)
	5 4 2 5		Sandra Tipton Mother 4750 Drayton Green, Ba			
<u>u</u>)	es 1 a of Hea litern rothe		20a. Method of Disposition 20b. Place of Disposition (Name of West of Acquaint of Place) 20b. Place of Disposition (Name of West of Acquaint of Place)		20c. Location -	City or Town, State
Бант	permit. Pages Department of H Important: If ite any injury or of once.		1 Burial 2 Cremation 3 Removal from State Wesneren A company of other place) 4 Donation 5 Other (Specify) 4-14-	-2006	Odentor	n, MD
alt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility III 1	ose Fune	eral Hon	ne, Inc.
מ	8 8 1 8 8	\	1328 Sulphur Spring	Rd., Ar	butus,	MD 21227
1	CH ST		2 f.s.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Onset and Death
	/Medical		resulting in death) Due to (or as a consequence of):			OTEHOVIT
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ב ב	be executed ician and burial-transii	Ex	resulting in death) Last Due to (or as a consequence of):			
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Q	the death certifica y the attending phi iched for use as th	Physician/Medi				
ŏ	h cer andir use	J.	IF FEMALE: 23c. If yes, outcome of pregnancy 1		23d. Dat	e of delivery
מ	deat e attr	icie	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Moi	nth Day Year
		hys	9 ☐ Unknown			
'n.	The law requires that tte has been signed b page 2 should be deta	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contr	ribute to the cause of death?
cords	en si			1 🗆 Y	es 2 No	3 Probably 4 Unknown
ဝ	awre	plet		24a. Was a	n 24b. V	Were autopsy findings available prior to completion of cause of
ř	sician: The law certificate has b irector, page 2 s	Completed		perform	med?	leath?
		0	25. Was case referred to medical 26. Place of Death			2.00 22.10
<u> </u>	ysician: Is certific director,	O B	examiner? 1 Yes 2 No	me 5 Reside	ence 6 Othe	er (Specify)
Ö	g Ph er th seral	n: T	(Month Day Vand) Initial Made	28d. Describe ho	ow injury occurr	ed
0	ath. r: Afrie fur	atlo	1 Natural 5 Pending (Month, Day 19ar) Injury Work? 2 Accident investigation M 1 Yes 2 No			
DIVISION	r Attending Phy ler death. irector: After this by the funeral d	tific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	treet and Numb	er or Rural Route Number,
5	s after selection and selection sele	Certification	Dullang, vio. (apoch)/	0.0, 0 0	, otalo,	
	hour hour uner lly fill		29a. Certifier (Check only (Ch	and due to the ca	ause(s) and ma	nner as stated.
	To the Hospitel or Attending Physician: white 24 hours after dealth at the Funarel Director. After this certifical completely filled in by the funeral director.	Medical	one) and manner stated.			
	With To COM	2	29b. Signature and title a certifier 29c. License number	2	9d. Date signed	(Month, Day, Year)
			/ Whilesony/ Voosile	00	4 11	106
			30 Name and address of parton who completed dause of death (Item 23a) (Type, Print)		,	*
	,		F-manda Phillips 3001 S. Hanover	74	rect	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 2006 32. Registrar's Signature			
	negisti	ul .	Will To Food Wallet			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HARRIS BEATRICE 10:10 AM 13 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🛣 F Yrs. 88 Director 161-24-8986 22 1918 VIRGINIA Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mudical Examples intrust by notified at 1 Yes 2 No Director MARYLAND HARFORD CO **EDGEWOOD** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 603 LACEWOOD DRIVE 21040 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4th grade CLOCK MAKER N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ S. ROSE HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Gaittings/Grandson 603 Lacewood Dr., Edgewood, Md., 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State inlury 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 04-19-06 BALTIMORE, MARYLAND 21. Signature Furl a Service Licensee 22. Name and Address of Facility
WM C _ROWN COMMUNITY FUNERAL HOME-HARFORD, P
321 S PHILADELPHIA BLVD, ABERDEEN. MD 21001 any it 23a: Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tany, Learning to immediate cause. Enter Underlying Cause (Disease or injury Die to (or as a nonsequence of) Examiner burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate atra I fel 1 Yes 2 No 1 ☐ Yes 2 ☐ Yo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Describing Physician: To the best of my knowledge, death uncorrected the time date and place, and due to the cause(e) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 20a Cartifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) David S P 3 2297 Apr. 114 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN, 614 W. MACPHAIL ROAD, SUITE 106, BEL AIR, MD 21014 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 1 9 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar		State of	Marylar	nd / Depa	artmen	t of H			ental Hyg		006	12229
			1. Decedent's Name (First, Midd	le, Last,)							2. Date of Dea			3. Time of Death
	Physic /Medi Examii	cal	Ruby 4a. Facility Name (If not institution	n, give	Luci				dle Town, or	Location o	of Death	Month April	17 4c. 0	Year 2006 County of Death	9:50 A M
	Funeral		Manor Care Ru: 5. Social Security Number	6. Se:	x 7	. Age (In yrs.	. last birthday)	Rux If Under Months		If Under 2	24 Hrs.	8. Date of Birth (Month, Day	1	Baltimoi	Ce place (State or Foreign intry)
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	e Maryla 8e-1 shov diffied at	ctor	Maryland Balt:		е		ity, Town or Lo Glenmon								10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
	or 2	Dire	10e. Street and Number					10f. Zip					0g. Citiz	en of What Cou	intry?
	s 23s	rai	6920 Donachie I						1239					U.S.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Medical Examinar must be routhed at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	ried	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? X No		Was Deced If Yes, spec 1 \By Yes		n, Mexican Specify:	gin? (Sp <i>e</i> , Puerto F	cify Yes or No- Rican, etc.)	İ	4. Race - Amer Black, White Specify:	, etc.
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Maryland	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "treumatic event, the Men	To Be (17. Father's Name (First, Middle M. P.	Last)		Ling				18. Mother	r's Name 1ian	(First, Middle,	Maiden S	•	lor
lar,	and N is ma		19a. Informant's Name/Relation	ship (Ty	rpe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	Route Number	, City or	Town, State, Zi	p Code)
_	ss 1 and of Health litem 27 r other tr		Stephen Hurdle 20a. Method of Disposition		(Son	20b. I	694 Place of Disponentery, crem	sition (Nan	ne of	a)	D	ate		Mary 1 ation - City or T	and 21215 own, State
Baltimore,	Pages ment of ent: If it		1 XBurial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (3	Specify)		ate	Lawn	Cemet	erv	A		06^{20} , E	ast	Point,	Maryland
Ball	permit. Departr Importe eny injit		21. Signature of Funeral Service	cicer	Kom	wike) 22	. Name an W. Da 1005	d Addres brow Dund	s of Facility Ski/C alk A	hojn ve.	acki Fu Baltimo	nera re.	1 Homes Marvlan	P.A. d 21224
	Pnysician		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final	r compli t only or	ne cause on eac	ın iine.	th. Do not ent	er the mod	le of dying	g, such as o	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
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8760,	ate be executed hysician and he burial-transit	icai Examiner	that initiated events resulting in death) Last			as a consec	quence of):								
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rds, P.	quires that t n signed by ald be deta	by	Part II. Other significant conditi	ons con	ntributing to dea	th but not res	sulting in the u	nderlying ca	ause give	n in Part I.			acco use		he cause of death?
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Ž	o : □	To B	examiner? 1 ☐ Yes 2 🙀 No	Н	lospital:	atient 2	ER/Outpatien	t 3 DO	A Othe	r		e 5 ☐ Reside		□Other (Specil	(v)
	ling After une	1.0	27. Manner of Death 1 Natural 5 Pendic invest		28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	M 2	8c. Injury Work		21	8d. Describe ho			
Division		Certification	3 Suicide 6 Could 4 Homicide determ		28e. Place of building	Injury - At h	ome, farm, stre	eet, factory	, office		2	8f. Location (St. City or Town		Number or Rura	al Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dire completely filled in b	edical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Phys Examir	sician: To the base ner: On the base and manne	is of examina	owledge, death ation and/or inv	occurred a restigation,	at the time in my op	e, date and inion, death	place, ar occurre	nd due to the ca d at the time, da	use(s) at ate and p	nd manner as s lace, and due to	tated. o the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifie	ir /	7 4	0 1	1	_	. License			1		signed (Month,	* '
,	3)	1	30. Name and address of person	who co	mpleted cause	of death (Item	m 23a) (Type,					4			>
			31. Date filed (Month, Day, Year	1, 2	mpleted cause	Timo istrar's Signa	Num	rd	Tin	nonce	ım,	MD	21	093	
	Sta Registr			วกกล	A.J.	se a	1 As	K)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🖰 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician DARRELL JACKSON, SR. 1149 2006 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA RALTIMORE HOPKINS BAY VIEW MEDICAL CTR JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, D3 · Z9 6. Sex 1 **2** M 2 ☐ F Birthplace (State or Foreign Country)
 SC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 47 Yrs. 250.11.7577 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show il Hygiene. other then "natural", or iteme 23a or 28a-f ehov vent, the Mudical Examinat must be notified at MD Baltimore 1 X es 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5316 Goodnow USA Koad 21206 Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer NIA 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ie marked of Pages 1 and 2 should be Freddie Jackson Grace Gosset 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a'Vel Baltimore MD 21206 Daughter . 5316 Boodnow Road item 27 i Jackson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important: If its eny injury or ot once. 1 Surial 2 □ Cremation 3 □ Removal from State Baltimore MD 04/18/06 Mt. Zion 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaug 4905 Work Rd Baltimore ND 21212 Vaughn ("Greene Funeral Styls. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SHOCK /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed INTRACRANTAL MASS that initiated events resulting in death) Last the attending physicien end ned for use as the burlal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IDS IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy performed? this certificate 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **V** □ Natural 5 Pending death. 1 Tes 2 No investigation Director: / <2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after de To the Funerei Direct completely filled in by t

DR. DENISE 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only 29b. Signature and

Medical

State

Registrar

1 9 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AVENUE

29d. Date signed (Month, Day, Year)

BALTIMIORE MDZ1224

			Please	Type or Print in Black	Indelible Ink. Ensure	All Copies Are	Legible.
			1_ For	-	epartment of Health and	Mental Hygier	enns 12231
			Registrar		Certificate of Death	Reg. N	
	Physic	ian	Diana Ale-	a Jackson		Month D	Oay Year 3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give	re street and number)	4b. City, Town, or Location of Dea		4 2006 4 13 A M
	LAGITIII		Sinai Hospita		Baltimore	2	
	Funeral	Г	5. Social Security Number 6. S	Sex 7. Age (In yrs. last birth	Months Days Hours Mir		9. Birthplace (State or Foreign Country)
	Director	'	Usual Residence of Decedent	51	rs.	5-15-192	+6 /nD
	yland		10a. State 10b. County	10c, City, Town	or Location		10d. Inside City Limits
	a Mar	ctor	MD	Bal	timore		1 ☐ Yes 2 MNo
	with th	Director	10e. Street and Number	X	10f. Zip Code	10g. C	Citizen of What Country?
	72 hours after death with the Maryland hatural, or items 23e or 28e-f ahow dical Examinat must be notified at	Funeral	7000 yatarubo	12. Was Decedent Ever in U.S.	2/207	Specify Yes or No-	14. Race - American Indian,
9	after d or iten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	to Rican, etc.)	Black, White, etc.
003	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
15-(n 72 h "natu	lete	15. Decedent's E (Specify only highest gr	ducation 16a. [Decedent's Usual Occupation Give kind of work done during most of wo Ko DO NOT use retirad)	orking 16b.	Kind of Business/Industry
21215-0036	within iene.	Completed	Elementary/Secondary (0-12)	Compge (1-4or 5+)	Domestic		mestic
	be filed ital Hygie id othar evant, II	BeC	17. Father's Name (First, Middle Last			me (First, Middle, Maide	on Sumame)
ylaı	2 should be filed withir and Mental Hygiene. is marked othar than aumatic evant, It e M.	To	Leon N. Whe	atley	Hele	na Eval	S
Maryland	12 sh h and 7 is m traum		114. Informant's Name/Relationship	C /// 1 1 -	Mailin J Ad ress (Street and Number or F	11.	or Town, State, Zip Code)
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23e or 28e-1 ahow other traumatic event, Ire M. dical Examinar must be instiffed at		20a. Method of Disposition	Or. / Husband for	Disposition (Name of	Date 20c	Location - City or Town, State
altimore,	0 0 == =		1 Burial 2 Cremation 3 C	Removal from State	crematory or other place)	0/2006 Tin	de and
alti	permit. Pag Department Importent: I any injury o		21. Signature of Fune al Servide Lio		Name and Address of Free N	re Funer	I Services
<u> </u>			raughn . x	heere	8728 Liberty Rd.	Randallet	own, MD 2/133
			shock, of beart failure. List only	plications that caused the death. Do no one cause on each line.	t enter the mode of dying, such as cardi	c or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ancer		Onset and Death
	Examiner			Due to (or as a consequence of			
		Jer	Sequentially list conditions, if any, leading to immediate	b. Pleural e. Due to (or as a consequence of	ffusions		
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events		drome		
60,	oe execian a		resulting in death) Last	Due to (or as a consequence of):		
687	rtificate b ng physi as the b	Physician/Medical		_ d			
Box (eath certii attending for use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
	death se atte	sicia	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	that the de ed by the detached	Phys	9 Dunknown	9□ Unknown			
	Se uc	by	Part II. Uther significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? 2 No 3 Probably 4 Voluntered
Sor	v require been sig should b	Completed					
Records,	The law ate has page 2 a	dmo				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		0	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ☑ N ath Check onl one	1 Yes 2 No
of <	diis	To B	examiner? 1 ☐ Yes 2 1 No	Hospital: 1 Malnpatient 2 ☐ ER/Outp		dome 5 Residence	6 □Other (Specify)
			27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Tir	ne of 28c. Injury at work?	28d. Describe how inju	
Division	Vttandii death. ctor: A y the fu	icat	2 Accident investigatio		M 1 Yes 2 No	29f Looption (Street e	and Number or Rural Route Number.
<u>></u>	of or Attand after death Diractor: /	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	r, street, factory, office	City or Town, Sta	
-	To the Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the fune		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge,	death occurred at the time, date and plac	e, and due to the cause(s) and manner as stated.
	To the He within 24 To the Fu	ledical	one)	and manner stated.	or investigation, in my opinion, death occ	urred at the time, date ar	id place, and due to the cause(s)
	To To I	2	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
•			TO NECETIVE	mo.	Le3 000	A	ipra, 14, 2006
			ARUNA ROKK	completed cause of death (Item 23a) (T	SPITAL OF BALTIMO	RE, 2401 W	ate signed (Month, Day, Year) April, 14, 2006 Belvedere Ave Baltimore MD 21215
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	to the	· / · · ·	DOMINIONE IND 21213
	Registr	ar	AKK1 9 2008	Aller A Fi			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 4c per doc 9555 5-11-06 vt.
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** AM John 500 2006 ouise /Medical 4c. County of Death inore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner extransvil Haven Home Months Days Hours Min. 8. Date of Birth (Month, Day, Aug. 17) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** 216-14-7368 1 □ M 2 X F Yrs. Director nar land Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, its Madical Examination unit be notified at ange. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 102 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 You If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ack Specify: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ma ome A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be non ames ora 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) md, 21223 Shirley mill W. Lexina ton St - daughler 1021 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Qurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation /5 ☐ Other (Specify) -2-0mdi butus memoral 22. Name and Address of Facility uneral Service Licens FREdHILTON Balto, md. 21229 Jaky P, march Reneral Home 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or pear failure. List only one cause on each line. Approximate Interval Between Onset and Death UMONIA Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) detached the 9 Unknown by signed b 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ANCOI 1 ☐ Yes 2 ☐ No 3 Probably Completed 492H 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 2 1 24a. Was an autopsy performed has certificate 1 Yes _2 **__**∕No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural Injury 5 Pending 1 Tes 2 No death. 2 Accident investigation within 24 hours after death To tha Funaral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Mell 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASNEEM 7220 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

Please Type or Print in Black Indelible Ink Bryant C Jones State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Day April 15, 2006 0052 hrs Medical Examiner Bryant Jones 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore City **Baltimore City** University Hospital - Shock Trauma If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreian Months Days Director 220-92-3171 1X M 2 F 4204/05/1964 MD Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show Md. N/ABaltimore rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ▭ 1020 North Augusta Avenue 21229 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes if Yes, Give Year 3 Widowed 1 Yes 2X No specify: Black 4 Divorced Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72 Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. fant: If item 27 is marked other than or other traumatic event, the Medical. MD 21215-0036 12 Electrical Company Electrician 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) F. Charles Linda J0nes Α. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisa 1020 No. Augusta Ave., Baltimore, Md. 21229 Jones 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Department of Woodlawn Cemetery 4/21/2006 Baltimore, Md. Other Specify Name and Address of Facility
step_Brothers Funeral Se
300 Eutaw Pl., Baltimore Signature of Funeral Service Licens 21217 Approximate Interval 23a, Part I. Enter the disease, or complications that caused death, Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and g UNPENDED **AMENDED** attending physician or use as the burial Physician/Medi Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death Month Day past 12 months? 2 Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot Natural FOUND: 1 Yes 2 V No

Hospital or Attending Physician: The law requires that the death certificate be 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis rely filled in by the funeral director, page 2 should be detached for use as the buring within 24

5 Pending Apr 14, 2006 2155 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 1020 N. Augusta Ave, Baltimore, MD determined (Specify) Townhouse / Rowhouse 4 V Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. April 15, 2006

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year, State Registrar APR

32. Registrar's Signature ORIGINAL

Medical

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of I			giene Reg. No:	16	12234
	Physic /Medi		1. Decedent's Name (First, Middle, La	JUD,	D			2. Date of Dea Month	pay Th	Year OO6	3. Time of Death 4.15A. M
	Examir		4a. Facility Name (If not institution, giv NORTHWESTERN HO 5. Social Security Number 6. S	SPITAL CEN	ITER e (In yrs. last birthday)	•	Location of Death CIMORE If Under 24 Hrs.	8. Date of Birth	4c. County BAI	of Death	ORE CO
	Director		228-10-7458 Usual Residence of Decedent	ZM 2□ F	91 Yrs.	Months Days	Hours Min.	(Month, Day DEC. 31	(, Year)		place (State or Foreign ntry) GINIA
	Marylar a-f show	tor	10a. State 10b. County MARYLAND N/A		10c. City, Town or Lo	ication IMORE				1	10d. Inside City Limits 1 Yes 2 No
	with the	I Director	10e. Street and Number 824 E BELVED.	ERE AVENUE		10f. Zip Code	212	. 1	10g. Citizen of V		ntry?
920	72 hours after death with the Maryland naturel', or items 23a or 28a-f show disal Examinar must be notitled at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Moivorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	Ever in U.S. 13. No	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
21215-0036	within ene. then *	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12) 8th grade	ducation de completed) College (1-4or 5	(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired K LIFT DR	during most of work)	ing	16b. Kind of Bu	siness/Ind	
Maryland 2	uld be filed fental Hygirked other tic event,	To Be C	17. Father's Name (First, Middle, Last) ANDREW LEE JUDD		TOK	K DIFT DK	18. Mother's Name	e (First, Middle, i	Maiden Sumam		ENITCALS
	s 1 end 2 should be filled if Health and Mental Hyg Item 27 I e marked oths other traumatic event,		19a. Informant's Name/Relationship (7/3/2		ng Address (Street a	and Number or Rura	al Route Number	r, City or Town,		
altimore,	80 5 = 9		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place ANCH BAPT	θ)	Date	20c. Location - DINWIDD	City or To	own, State
Balt	permit. Pa Depertmer Important any injury once.		21. Signature of the results of the	our lever	W.	Name and Address LLLIAM C 206 W NOR	BROWN COM TH AVENUE	i e		HOM	E P.A.
4	Physician /Medical		23a: Part . Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each lin	the death. Do not entrine.	er the mode of dying	g, such as cardiac (or respiratory arm	est,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	6. Brile	a consequence of):	preur	nonig				
68760,	ficate be executed physicien and s the buriat-transit	edicai Examiner	causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
P.O. Box 6	the death certif by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal déath 3 ☐	Ectopic pregnancy			23d. Date Mon	e of delive	ory Day Year
	aw requires that s been signed t s should be deta	ted by P	Part II. Other significant conditions of	ontributing to death bu	at not resulting in the un	derlying cause give	Gulfati			ibute to th 3 ☐ Prob	ne cause of death?
Division of Vital Records,	iicien: The law r certificate hes be rector, page 2 sh	Completed by	Cheloworafala	w Like	ne			24a. Was a autops perform	ned? p	Vere autor rior to con eath? Yes	psy findings available inpletion of cause of 2 No
f Vit	Physicier this certif at directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Unipatie	nt 2 ER/Outpatient	t 3□ DOA Othe	26. Place of Death	ALAITE CONTRACTOR	700	r (Specifi	·)
sion o	To the Hospital or Attending Physicien: The within 24 burs after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification;	27. Manner of Death 1 Deatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Year) Injury			28d. Describe ho			,
<u>N</u>	oital or At urs after d arel Direct		4 Homicide determined	building, etc				28f. Location (St. City or Town	n, State)		
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physical Example 2 ☐ Medical Example	viner: On the best of the sais of and manner sta	of my knowledge, death examination and/or inv ted.	estigation, in my op	inion, death occurr	ed at the time, da	ause(s) and mar ate and place, a 9d. Date signed	nd due to	the cause(s)
	F ≯ F 8		DR Ranger 30. Name and address of person who of	agay h	Death (Item 23a) (Time 1	DS	4288		April	18	# 2006
	(to	31. Date filed (Month, Day, Year)	y I Ob	r's Signature		Morety	west t	Mula	7 0	Zille
J.	Sta Registr		APR 1 9 20	06	s St. Age						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1ten 19b per fh 9854 4-19-06 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death .Day2006 APRIL 17, SARA JACOBS

1 - State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ATRIUM VILLAGE ASSISTED LIVING OWINGS MILLS 7. Age (In yrs. last birthday)
Months Days Hours Min. Development Bay 19917 5. Social Security Number Birthplace (State or Foreign Country)
 M **Funeral** 1 □ M 2 🕅 F 219-01-8735 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location r then "natural", or iteme 23a or 28a-f ehow the Medical Exam wir must be notified at Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8400 PRAIRIE ROSE PLACE 21208 ss 1 and 2 should be filed within 72 hours after deeth of Heelth and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23; other traumatic event, the Medical Examble of interest. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ NATHAN COHEN TILLIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street are Number or Rural Route Number, City or Town, State, Zip Code) HOWARD JACOBS / SON 8400 PRAIRIE ROAD PLACE - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of H ant: if ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) BETH ISAAC ADATH ISRAEL 4/18/2006 DUNDALK, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Toland 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) METRASTAMIC Savanous CELL /Medical Due to (or as a consequence of) Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit ed by the attending physicien and detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical

IF FEMALE: 23b. Was decedent pregnant

in the past 12 months?

9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 □Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

Year

LIVING

3. Time of Death

BALTIMORE

USA

MD

10d. Inside City Limits

WHITE

WINOKUR

Approximate Interval Between Onset and Death

10 mon Tet

1 ☐ Yes 2 🕅 No

12:30 PM

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1□ Yes 2 12 No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No NA

25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Special) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

OWINGS MILLS, NO 21117

(Check only one) 29b. Signature and title of certifier

29a. Certifie

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

028792

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who form leted cause of death (Item 23a) (Type, Print)

HOWARD JACUSS, 20 20 Chossians onive#14 31. Date filed (Month, Day, Year)

State Registrar

h

signed b

s been sign

certificete has

: After this certific funeral director,

Director:

within 24 hours after To the Funeral Direct

or Attending Physician:

þ

Be Completed

ဥ

Certification:

Medical

32 Registrar's Signature

06-02569 Barbara Kidd

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Daibala Nigg		- For State - For State - Certificate of Death - Registrar	Reg No. 2006 12236
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) BARBARA ANN KIDD	2. Date of Death Month Day April 16, 2006 3. Time of Death 0213 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L	ocation of Death 4c. County of Death
Funeral		Smallwood Drive Bridge Waldorf 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	Charles If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or
Director		215 90 4110 1 M 2 X F 40 Yrs Months Days Usual Residence of Decedent	Hours Min. Oct 16, 1965 Foreign Country) Maryland
w any	t	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
nyland Sa-f sho	Director	MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code	1 Yes 2 XX No
ith the Maryland 23a or 28a-f show notified at once.			002 UNITED STATES Danic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is narked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Mexican, Puerto Rican, etc.) White, etc.
nours aff	od be	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Decupation during most of working life.	on (Give kind of work done 16b. Kind of Business/Industry
036 Athin 72 h ene. rr than "r Medical E	Completed	12 College (1-4 or 5+) SECRETARY	PLUMBING
215-0036 be filed within 7 ttal Hygiene. *ked other than ent, the Medica	Be Co	17. Father's Name (First, Middle, Last) WILLIAM JOSEPH BAKER, SR.	8.Mother's Name (First, Middle, Maiden Surname) BETTY Y. PHILLIPS
D 21 should be and Men 7 is mar	리	19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street WILLIAM & BETTY BAKER (PARENTS) 9519 EVERONA F	and Number or Rural Route Number, City or Town, State, Zip Code)
re, MD I and 2 sho Health and fitem 27 is	ŀ	20a. Method of Disposition 1 XX 8urial 2 Cremation 3 Removal from State crematory or other place)	
Baltimore, permit. Pages I at Department of Hee Important: If ite		4 Donation 5 Other Specify: RESURRECTION CEMET	TERY 2006 CLINTON, MARYLAND
Bal permi Depar Impo injur		Naus 1. Mas mocasi ALEXANDRIA	of Facility LEE FUNERAL HOME. INC. 6633 OLD FERRY ROAD. CLINTON. MARYLAND 20735
Physician /Medical		23d. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s failure. List only one cause on each line. Multiple Injuries	such as cardiac or respirátory arrest, shock, ór heart Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ited d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
760, ficate be executed s physician and the burial - transit	edical	UNPENDED X AMENDED item#11,perInf,G856,6/28/06	TT
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death To the Financian Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri.	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy 23d. Date of delivery Month Day Year
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
P.O. es that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
n of Vital Records, P.O. Box 68' ing Physician: The law requires that the death certificate has been signed by the attending tuneral director, page 2 should be detached for use as!	ompleted		24a. Was an autopsy findings available prior to completion of cause of
Rec	Com	25. Was case referred to medical 26.Place	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital ysician his cert	o Be		of Death (Check only one) Other A □ Nursing Home 5 □ Residence 6 ☑ Other Scene
n of Vital ording Physician: h : After this certif	cation: T	27. Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury 1 Natural 5 Pending FOUND: 1 Years	y at Work? (es 2 V No Motorcyclist struck fixed object
Division To the Hospital or Attendit within 24 hours after death To the Funeral Directors , completely filled in by the fi	ificat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office but	uilding, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Di lospital 1 hours a mueral	l Certific	4 Homicide determined (Specify) LDCal Street 29a Certifier Check page 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	Smallwood Drive Bridge, Waldorf, MD
To the Ho: within 24 h To the Fm	ledical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated	death occurred at the time, date and place, and due to the cause(s)
	Ž	29b. Signature and title of certifier 29c. License O.C.N	
T		30. Name and address of person who completed cause of death (Item 23a)	
10	tate	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature	altimore, MD 21201
S Regis		31. Date filed (Month, Day, Year) APR 1 9 2006	

		_ 1	For State Registrar	. 1040				d / Depa		t of H	ealth a	and M			21116		22	37
2	被	žζ	1. Decedent's Name	(First, Middle, L	.ast)							,	2. Date of Month	Death	Day Y	ear	3. Time	of Death
	Physici /Medic		Jean Eliz	abeth K	oons									15	, 2006		9:00	PM M
	Examin		4a. Facility Name (If	_		number)			4b. City,	Town, or	Location	of Death			4c. County of	Death		
3			Manor Car	re Ruxto	n						owso:				Baltimo			
20	Funeral Director		5. Social Security No. 216-12-20	062	Sex 1 ☐ M 2:54		(In yrs. I	iast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, 11/13	Birth Day, Ye 1/19	9ar) 14 MD		ace (State try)	e or Foreign
	and and		Usual Residence of 10a. State	10b. County			10c. City	y, Town or Lo	ocation							10	d. Inside	City Limits
	4 sho	ō	MD	Baltimo	ore		Lut	hervil	le Ti	moni	11m						1 □ Ye	es 2XNo
	28a	Director	10e. Street and Nun						10f. Zip					10g.	Citizen of Wha	at Count	try?	
	3a o	0	325 E. Ti	monium 1	Road				210	93				Ur	nited St	tate	s	
	ms 2	Funeral	11. Marital Status		12. Was D	ecedent E	ver in U.	S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Sp	ecify Yes or Rican, etc.)	No-	14. Race -	America	an Indian,	
9	or Ite	F	1 Never Marrie	ed 2 Married		S 2 N	0	1	iires, spek 1 ∐ Yes		Specify:		nican, etc.)			White, e		
93	ural',	d by	3 Widowed	4 Divorced	Year	r Dates:			1 🗆 163	212110	opouny.				Specify: W	hite	3	
5-	72 h	ete	(Speci	 Decedent's ify only highest g 	Education trade complete	ed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ition luring mos	t of work	ing		o. Kind of Busin	ess/Ind	ustry	
21215-0036	filed within 72 hours after death with the Maryland Hygliene. ther than "natural", or Items 23a or 28a-f show that than "natural", or Items and the rediffied at	Completed	Elementary/Secon	ndary (0-12)	Colleg	e (1-4or 5+	+)	Bank						Бе	nking			
d 2	Hygie ther ther	ပိ	17. Father's Name (First, Middle, La	st)			Dunn				er's Name	e (First, Midd	lle, Mai	den Sumame)			
an	ould be Mental arked o	To B	William 1	Eugene Ko	ons						Ella	Fran	ces Wi	lhe]	Lm			
Maryland	iit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan riment of Health and Mental Hygiene. Intent: if them 27 is marked other than "natural", or floms 23e or 28e-f shown intent: if them 27 is marked other than "natural", or their results a routilised at night or other traumatic event, the Madical Examinar must be rediffied at a night or other traumatic event.	-	19a. Informant's Na	me/Relationship	(Type, Print)			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Nun	nber, C	ity or Town, Sta	te, Zip	Code)	
	1 and 2 Health a em 27 is ther trai		Mrs. Nanc	y C. Ber	ry/Niece	Э		325 I	E. Ti	moniu	ım Ro	ad L	utherv	/ill	e Timor	ium	, MD	2109
Ē,	tem of Hei		20a. Method of Disp				20b. P	lace of Dispo	sition (Nar	ne of ther place	9)		Date Apr 19	200	c. Location - Cit	y or Tov	wn, State	
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Baltimore,			21. Sign June of Fun	neral Service Lic	ensee	WA	2008		2. Name an				Alter					
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	Physician		23a. Part1. Enter the shock, or hear Immediate Cause (disease or conditions)	Final				Do not ent									Approxim Interval B Onset and	etween d Death
	/Medical Examiner		resulting in death)	- 1	Due	to (or as a	consequ	uence on:	00								rea	15
		2	Sequentially list con	nditions,	b. Due	to (or as a	DIC		00	17/	ry							
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	ate be executed hysician and he burial-transit	xar	that initiated events resulting in death) L	.ast	c	to (or as a	consequ	uence of):								+-		
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O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown		4□Pr	outcome o re birth 2 egnant at t nknown	2 ☐ Fetal	Ideath 3[Ectopic pr Other (sp					_	23d. Date o Month		y Day	Year
, P.O.	that i		Part II. Other significant	icant conditions	contributing t	o death bu	t not resu	ulting in the u	nderlying c	ause give	n in Part I		23e. Di	d tobac	co use contribu	te to the	e cause of	f death?
Records,	uires tha signed I	d by											1 (Yes	2□No 3[Proba	ibly 4	∄ U <i>n</i> known
Õ	w require been si should I	Completed											24a. W	as an	24b. Wer	e auton	sv finding	s available
Re	sicien: The law s certificate has t irector, page 2 s	щ											au pe	topsy rforme	? prio	r to com th?	pletion of	cause of
tal	an: T	Ö	25. Was case retern	red to medical							26 Place	of Doath	1 ☐ Yes	$\overline{}$	No 1	Yes	2□ No	
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o	Attending Physicien: r death. ector: After this certifics by the funeral director, I		27. Manner of Death	1	28a. Da	ate of Injury	/	28b. Time o		8c. Injury	at				injury occurred	эрвспу,		
ion	ttending f death. ctor: After y the funer	atio	1 Natural 2 Accident	5 Pending investigation		fonth, Day	(dai)	Injury	М		res 2 🗌	No						
Division	ar de	tific	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 289. PI	ace of Inju	ry - At ho	me, farm, str	eet, factory	, office			28f. Location City or 1	(Stree	t and Number (or Rural	Route Nu	ımber,
Ö	s after or selection of the control	Certification:				maing, etc.	. (Opecin)	′′					Oily or i	Om, 0	rate)			
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)	Certifying I	Physician: To aminar: On th and m	the best of e basis of nanner stat	f my kno- examinat ed.	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date an Pinion, dea	nd place, ith occurr	and due to the red at the tim	ne caus e, date	e(s) and manne and place, and	er as sta due to	ited. the cause)(s)
	To t To t	Σ	29b. Signature and	the of certifier	/_ ,				290	. License	number	2		29d.	Date signed (A	Aonth, E	ay, Year)	
	1		1/1	Con	leeln				X	1-00	128	40	/		4-17	-64	5	
	Q Y		30. Name and address	ess of person wh	o completed o	ause of de	ath (Item	23a) (Type,	Print)	10	P	3	70	ins	Date signed (A	MD	2/	204
1	Sta	ite	31. Date filed (Mont		34	Registra	r's Signa	ture /	10 -						-			
	Registi	rar	Al	PR 1 9 2	006	3 Silver	a de la	Aca										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year KURTIS **Physician** ZOP M MICHAEL APRIL 5 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL HOPKINS BALTIMORE THE JOHNS CITY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct. 3, 19 Birthplace (State or Foreign
 Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Yrs 316-58-4701 52 Lilinois Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State * show r 28a-f show 1 ☐ Yes 2 X No Director Virginia Fairfax Clifton 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code ir than "naturel", or items 23a or the Medical Examiner must be 6704 Cedar View Court U.S.A. 20124 death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Lawyer Law 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be f nent of Health and Mental I ant: If Item 27 is marked or William Kurtis Antonia Kariotis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6704 Cedar View Ct., Clifton, VA 20124 Rhonda Kurtis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Himportant: If ite any injury or of once. 1 N Burial 2 □ Cremation 3 □ Removal from State National Memorial Park 4/20/06 4 Donation 5 Other (Specify) Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
National Funeral Home 7482 Lee Highway, Falls Church, VA 22042 Mman Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. PANCREATIC ADENOCARCINOMA Immediate Cause (Final disease or condition METASTATIC MONTHS **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner SEPTI CEMIA NEG TIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physicien and deelached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performe 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) : After this c 1 Nnpatient 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MEDICAL DOCTOR APRIL 15, 2006 KES- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE ST, BALTIMORE, MD 21287 MANISH ARORA THE JOHNS HOPKINS HOSPITAL State Registrar

ORIGINAL

			For	State of Mar		epartment of h		Mental Hy	giene nn s	12239
			1 - State Registrar	<u> </u>		Certificate of	Death		Reg. No.	I has how O so
ł	Physici /Medic		Decedent's Name (First, Middle, Last Jae Hoon Le	e				2. Date of De.	1375, ZV	
¥.	Examin		4a. Facility Name (If not institution, give Baltimore Wash	street and number)	2	4b. City, Town, o	r Location of De		4c. County of De	()
			Baltimore Wash	ing his My	ethis con	Cinter,	Coplen	15 harni	1 Anne	Armaler
	Funeral		5. Social Security Number 6. Se	YM 2DE	In yrs. last birti	hday) If Under 1 Year Months Days	ff Under 24 H Hours Mi	rs. 8. Date of Bird	th v. Year) 9. 6	Birthplace (State or Foreign Country) outh Korea
	Director		212-71-0716 Usual Residence of Decedent	2	49	rs.		Sept 3,	, 1957 S	outh Korea
	and and		10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limits
	Mary -feh	tor	Maryland Anne Ar	undo 1		Glen Burni	0			1 □Yes 2X No
	1 the	Director	10e. Street and Number	under		10f. Zip Code	.e		10g. Citizen of What	Country?
	3a.0		656 Charente Cour	t #202		21	.061		South K	orea
	deet	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of H tf Yes, specify Cuba	lispanic Origin?	(Specify Yes or No	- 14. Race - A	merican Indian,
9	2 should be filed within 72 hours after deeth with the Maryland and Menthel Hygiene, and Menthel Hygiene, in marked other than "natural," or items 23s or 28e-f show aumatic event, the Madrell Examination and the notified		1 ☐ Never Married 2 [X] Married	1 ☐ Yes 2 XNo If Yes, Give		1 ☐ Yes 2 XNo		ono moan, etc.,	Spacifus.	
5-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					K	orean-Asian
	n 72 l	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of w	rorking	16b. Kind of Busine	ss/Industry
2	filed within Hygiene. ither than "	mc	Elementary/Secondary (0-12)	Cotlege (1-4or 5+) 4yr		Floor Med			Top F	looing
0 0	filed Hygi other	e C	17. Father's Name (First, Middle, Last)	491		rioor nec		ame (First, Middle,	Maiden Surname)	iooing
Maryland 2121	ould be Mental arked o atic eve	To Be	Gaesung Lee				Ju	ngsun	Kim	
ary	should and Men marke umatic	-	19a. Informant's Name/Relationship (T)	rpe, Print)	19b.	Mailing Address (Street	and Number or i	Rural Route Numbe	ar, City or Town, State	, Zip Code)
	1 and 2 Health a lem 27 ie		Youngseng Han Lee	/wife	65	6 Charente	Court #	202 Glen	Burnie, M	aryland 21061
ē.	S -= = 0		20a. Method of Disposition	1	20b. Place of	Disposition (Name of r, crematory or other place	ce)	Date	20c. Location - City	or Town, State
Ĕ	Pages nent of I int: if its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			undel Crema	· .	17/2006	Odenton,	Maryland
Baltimore,	permit. Page Department of importent: if eny injury or once.		21. Signature of Funeral Service Licens						Crematory,	РΔ
m —	8 G E E B		Quanta KH	mco		_1411 Annap	oolis Ro	ad Odent	on, Maryl	and 21113
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the	e death. Do n	ot enter the mode of dyir	ng, such as cardi	ac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Here	porto	(2)/4/a~		an cer		Onset and Death
	/Medical		resulting in death)	Due to (or as a c	consequence	f):				
П	Examiner		Sequentially list conditions,	b						
T	si ad	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	o echaupeanos	1).				
ν	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence o	<i>t</i>)·				
09	be e									
58760,	ficate be executed physicien and ts the burial-transit	edical		1.						
ROX	eath certifi attending for use as	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. Date of o	delivery
ň	The law requires thet the death certi site has been signed by the attending bage 2 should be detached for use a	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 [4□Pregnant at tirr		3 □Ectopic pregnancy 5 □ Other (specify) _			Month	Day Year
Ö	res thet the de signed by the a be detached f	Physici	9 Unknown	9□ Unknown						
ď.	s the	by P	Part II. Other significant conditions co	ntributing to death but r	not resulting in	the underlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ğ	w require been sig should b							1 🗆 ١	es 20 No 30	Probably 4 Unknown
Vital Records,	law re as be 2 sh	Completed						24a. Was	an 24b. Were	autopsy findings available o completion of cause of
Ĭ		МO						perfo 1 ☐ Yes	rmed? death	? es 2 100
<u> </u>	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?		/31 15			eath (Check only o	ne	
	Attending Physician: In death. Cotor: After this certification in the funeral director.	မှ	1 195 270140	lospital: runpatient			4 🗆 Nursing		dence 6 □Other (S	pecify)
Division of	ing Afte une une	on	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	'ear) 28b. Ti	ju r y Wor		28d. Describe h	now injury occurred	
<u>s</u>	Attendideath.	Icat	2 Accident investigation 3 Suicide 6 Could not be	20a Blace of faire	At home for		Yes 2□No	29f Location //	Street and Mumber of	Dural Davids Museline
<u>≥</u>	after death after death Director: /	Certification:	4 Homicide determined	building, etc. (m, street, factory, office		City or Tox	Street and Number or vn, State)	Hurai Houte Number,
	To the Hospitel or A within 24 hours after To the Funerel Directompletely filled in by		29a. Certifier Tecertifying Phy	sician: To the best of t	my knowledge	death occurred at the tir	ne, date and pla	ce, and due to the	cause(s) and manner	as stated.
	• Ho 24 h • Fur letely	edical	(Check only 2 Medical Exami	ner: On the basis of ex and manner stated	camination and	or investigation, in my o	pinion, death oc	curred at the time,	date and place, and d	ue to the cause(s)
	within To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)			1	m D		D48	3006	(04/13/	2006
	10		30. Name and address of person who ca	empleted cause of deal	th (Item 23a) (Type, Print)	1	().	12.	11 1000
	10		KO+1 15041	1-71.3	01 H	Vs pital	DV-1	121m	DMA	Jun h
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	Specke	,			
	Registr	ar	AINTO	- COUNTY OF THE PARTY OF THE PA	and Queen					

			State of Maryland / Department of Health and M 1- State September 2 Certificate of Death		7 11110	12240
	See See See See See See See See See See		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia /Medic	an al	Roberta C. Levery	April	12, 2	506 0611 M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	٠,	4c. County of D	eath C
	Funeral	18)	5. Social Security Number 9. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	h . 9.1	Birthplace (State or Foreign Country)
B	Funeral Director		122-40-1567 1 M 2 S F S 8 Yrs. Months Days Hours Min.	(Month, Day Dec 12.		New York
	pu »		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aaryla rehor	5	MD Anne Arundel Glen Burnie			1 ☐ Yes 2X No
	the N	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
	h with		239 St. James Drive 21061		USA	
	deet	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spettif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		mencan Indian,
36	tiled within 72 hours atter deeth with the Maryland Hygiene. ther then "natural", or items 23s or 28s-1 ehow that the Medical Examinar must be nutified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify:	
21215-0036	hour fural	ed b	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busine	hite ss/Industry
715	n "na n "na Medis	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) (Give kind of work done during most of working life. DO NOT use retired)	ing		,
2	d with	E O	12 none Cashier		Wal Mart	
pu	be file d oth	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle,	Maiden Sumame)	
7 3	d Mer narke	<u>٥</u>	Robert Charles Schleimer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Pura			Zin Code)
Maryland	nd 2 s. Ith an 27 le :		Philip Levery/spouse 239 St. James Drive Gl			
ē,	f Hea f Hea ltem		20a. Method of Disposition 20b. Place of Disposition (Name of comptent of comp	Date Duri	20c. Location - City	
Ĕ	Page nent c ant: If ary or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-1 show way injury or other traumatic event, the Medical Examinating the notified at once.		21. Signature of Foreral Service Licensee Ronald S. Wade. Director State Anatomy Booar	d 655 W	. Baltimo	re Street
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or			Approximate
	Physician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Strate Liver Disease Civilians or condition Strate Liver Disease Civilians or condition Strate Liver Disease Civilians	~ hoci	·c	Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. End Stage Liver Disease Circumstance of the condition of the condition of the condition of the conditions. Due to (or as a consequence of): Non-Alcoholic Steatonepad	7 7 7 0037	3	
	Examiner	_	Sequentially list conditions. b. Non-Alcoholic Steatonepad	titis		
	bed Isit	nine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Undertying Cause (Disease or injury			
	cate be executed physicien and ; the burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	ysicie	dicai	d.			
9		Med	IF FEMALE:			
Вох	death certifi e ettending id for use as	lan/	23b. Was decedent pregnant in the past 12 morths?		23d. Date of Month	delivery Day Year
0	that the death certiff ed by the ettending detached for use as	by Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			,
4	The law requires that the tite has been signed by the bage 2 should be detache	y Ph	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds	w require: been sig should b		Acute Kenal failure, Sepsis	1 □ Y	′es 2 V No 3 □	Probably 4 Unknown
Vital Records,	as be	Completed	Hepatic Encephalopathy	24a. Was autop	an 24b. Were	autopsy findings available to completion of cause of
E E		Соп		perfor	rmed death	? es 2□ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: 15/10004/for 2 FR/Outcaston			
of	Phys r this ral dii	1: To	1 Tes 255 NO 1 Tempatient 2 EH/Outpatient 3 DOA 4 Nursing Hot		lence 6 Other (S now injury occurred	pecify)
lon	Attending Ph r death. ector: After th by the funeral	ation	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,	
Division	r Attendi ter death. irector: A n by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		Rural Route Number,
Ω	spitel o ours af nerel D filled ir		29a. Certifier 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the o	cause(s) and manner	as stated.
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	ed at the time, o	date and place, and o	lue to the cause(s)
	To To	-	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	5-0711
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			2, 2000
			Y. Ballard 22 South Excene Street Baltim	Love, M	D 2120	
	Sta Registr	100000	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	negisti	ul	1221 9 2006 Barn & Agree			<u> </u>

06-02555 Rosa Regina Lloyd

Please Type or Print in Black Indelible Ink

osa Regina Lic		1- For State Certificate of Death		2006	1224
Physici	an/	1. Decedent's Name (First, Middle,Last) 2	2. Date of Death		3. Time of Death
/ledical Exami	iner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	April 15, 20	4c. County of Death	0845 hrs
		3653 Forest Hill Rd. Gwynn Oak		Baltimore Cou	
Funeral		Months Days Hours Min	8 Date of Birth	(MM/DD/YYYY) 9 Bird Foreig	in
Director		212-42-4083 1 M 2 XF 63 Yrs	DEC. 2	8,1942 00	untry) MARYLAN
an y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		·	10d Inside City Limits
Maryland 28a-f show d at once.	tor	MARYLAND BALTIMORE GWYNN O	AK		1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	itry?
with th				14 Race - Ameri	can Indian, Black,
r death or iten	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.)	White, etc.	
hours afte "natural", Examiner	þ	3 Wildowed 4 Divorced III Yes, Gise: 1 Yes 2 No specify:	rk done	Specify: 32	ACK ndustry
6 72 hou an "mail rail Exs	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life DO NOT use retired			, addity
5-0036 led within 7 Hygiene. lother than	omp	17. Father's Name (First, Middle, Last) PERSONEL WORK 18. Mother's Name (F	ER	HUMAN F	RESOURCES
21215-0036 uld be filed within 72 Mental Hygiene. marked other than r event, the Medical	Be C		First, Mildale, Mi	FIF	1//<
2121 should be find Mental is marked atic event,	2	19a Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rur	ral Route Numb	er, City or Town, State,	Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition (Name of cemetery, I	<i>RD, (</i> -)	WYNNOAK 20c. Location - City or	MD 2/207 Fown, State
Baltimore, permit. Pages ar Department of Hee Important: If ite		The surface of the place of the			
Baltin permit. P. Departmer Importan		21. Signature of Fun of Service Licensee ARBITUS (EMETERY) 04-2 22. Name and Address of Facility BR	2100	TR FULLE	PAI HOME
	4	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	AVE.	JR. FUNER BALTO, K	10.21217
Physician /Medical	7 6	factore. List only one cause on each line		st, snock, or neart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Impertensive atherosclerotic cardiovascular dispute to (or as a consequence of):	Sease		
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated events resulting in death). Last events resulting in death). Last Due to (or as a consequence of).			
executed an and al - transit	_	d.			
760, cate be exe physician a	Medical	X unpended item#1,23a,27,perME,g854,4/27/06 TT			
1876 tificate ing phy as the t			су	23d. Date of delivery Month D	ay Y ear
J. Box 687 t the death certific by the attending p	sician/	1 Yes 2 No 9 V Unknown			
by the check	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
s, P.O.	d by		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
cords law requi has been 2 2 should	Completed		24a Was ar autopsy	prior to co	opsy findings available ompletion of cause of
tal Rec rian: The L certificate P ector, page	Som		perform 1 Yes 2	ed? death? No 1 ✓ Yes	s 2 No
Vital ysician: nis certifi director,	o Be	25. Was case referred to medical examiner? 1 Ves 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing F		esidence 6 V Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should be to be the funeral director, page 2 should be the funeral director.	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28		w injury occurred	Occine
ivision or Attendi after death Director:	atio	2 Accident Investigation 1 Yes 2 No			
Divis	ertification:	determined (Specific)	Bf. Location (Str or Town, Sta	eet and Number or Rur te)	al Route Number, City
Division To the Hospital or Attendition 24 hours after death To the Funeral Director:	0	4 Homicide 29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du	ue to the cause(s) and manner as starte	ed .
To the Howithin 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated	he time, date ar	id place, and due to the	cause(s)
	2	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed <i>(Mon.</i> April 16 , 2006	th, Day, Year)
	ŀ	30 Name and address of person who completed cause of death (Item 23a)			
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			
St Regist					
		111 11 1 0 1000	·		

<u> </u>			1 - For State Registrar	State of M		d / Depa		nt of H		d Me	ental Hyg	leg. No.	06	the account of	2242
745.7	Physici /Medic		1. Decedent's Name (First, Middle, La Lillian Lettlo								2 Date of Dea Month pril	Day	200	өаг 6	3. Time of Death 2:40 P
	Examin	Sx. 13	4a. Facility Name (If not institution, give 4619 Northwood D	e street and number	7)		4b. City,		Location of D	re		7	County of	Death	
5	Funeral Director		212-42-2143	Gex 7. A I□M 2□XF	ige (In yrs.	last birthday) Yrs.	If Unde Months	n 1 Year Days		∕lin.	B. Date of Birth (Month, Day 1/30/1			Birthpl Coun	ace (State or Foreign try) and
	ter death with the Maryland frema 23a or 28a-f ehow free from the notified at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland		10c. Cit	y, Town or Lo								10	Od. Inside City Limits 1 Yes 2 No
	or 28a	Director	10e. Street and Number		-	Daili	10f. Zip	Code				10g. Citiz	en ol Wha	at Coun	try?
	ath w	rai	4619 Northwood D		. F	0 10			239	2 / 2	4 W No	U.S			and the
036	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-f ehow a Medical Exercit or marke molified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2X If Yes, Give Year or Dates	?] No		was Dece If Yes, spe 1 Yes		spanic Origin n, Mexican, Pi Specity:	(Speci uerto Ri	fy Yes or No- can, etc.)		4. Race - Black, Specify:	White, 6	etc.
Maryland 21215-0036	within 72 ho ane. than "natur	Completed	15. Decedent's E (Specify only highest grants) (0-12)	ducation ade completed) College (1-4or	5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done a	uring most of	working		16b. Kin	d of Busin	ness/Ind	ustry
121	73 75 15 15 15 15 15 15 15 15 15 15 15 15 15		12 17. Father's Name (First, Middle, Last	1		C	osmot	olog		Alama /	First, Middle,		utic:	ian	
lanc	ed la p	To Be	Benjamin Smith						Lilli			Maluell	umame)		
Mary	12 shouh and N 7 ie mai		19a. Informant's Name/Relationship (Kia Shaw / Grandd	• • • • • • • • • • • • • • • • • • • •			-				Route Numbe	-			
	1 an Heal Bm 2 ther		20a. Method of Disposition		20b. F	Place of Dispo				Da			ation - Cit		
imo	Page ment o ant: If ury or		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State (y)	9	butus	Memor	ial	Pk. 04						ryland
Baltimore,	permit. Pag Department Important: any injury o		21. Six ature of Funeral Serviça Lice	6-1		46	11 Pa	ark H	lgts. A	ve.	, Balti	imore			/H, P.A. and 21215
É	Pnysician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	19	can	-	de ol dying	g, such as car	diac or I	respiratory ari	rest,		2	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a											
,092	ite be executed ysicien and ne burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or a	s a conseq	uence of):									
.O. Box 68	it the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Novice 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	I death 3[Ectopic p Other (s _f					23	d. Date o Month		ry Day Year
α.	quires that in signed b uld be deta	ρ	Part II. Other significent conditions	contributing to death	but not res	ulting in the u	nderlying o	cause give	en in Part I.		1	bacco us es 2 🗆		1	e cause of death? ably 4 [Unknown]
I Records,	. The law requires that the rate has been signed by th page 2 should be detache	Completed								-	24a. Was a autop perfor	sy	prio	r to con	sy findings available pletion of cause of
Vital	Physician: The this certificate al director, pag	Be	25. Was case relerred to medical examiner?	Hospital:				Otho			Check only or				
of	ing Phys After this uneral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	jury	28b. Time of Injury		28c. Injury Work	at		5 1 Resid d. Describe h			Specify)
Division	al or Attendir s after death. Il Director: At ed in by the fu	Certification:	3 Suicide 6 Could not be determined	e 28e. Place ol Ir	njury - At he	ome, farm, str	eet, factor	y, office		28	II. Location (S City or Tow		Number	or Rural	Route Number,
)	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical (29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exe	nysician: To the bes miner: On the basis and manner s	of examina	wledge, death tion and/or in	n occurred vestigation	at the tim	e, date and pl inion, death o	lace, an	d due to the d at the time, d	ause(s) a late and p	nd manne place, and	er as sta I due to	ated. the cause(s)
	To the	¥	29b. Signature and title of certifier	zuro :	Pthy:	SICIAn	1	c. License	number 3590				•		Day, Year)
	2		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)	624		COA	MAUCH				, ,
	Sta Registr		31. Date filed (Month, Day, Year)	82. Regis	trar's Signa	iture 134			.,		V	,	•		

Physician

/Medical

Examiner

10a. State

Funeral Director

Be Completed by

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: if tiem 27 is marked other than "natural", or terms 23s ~~^^ any injury or other traumatic event. If a marked other than any injury or other traumatic event.

attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

Examine Physician/Medical þ Completed Be ٩ Certification: within 24 hours after deam.
To the Funeral Director: A Medical

resutting in death)	Due to (or as a consequence of): Secondamy to Du	Iselesi electri	e activish	1	Jahr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				,
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		oic pregnancy or (specify)		23d. Date of de Month	ivery Day Year
	athbuting to death but not resulting in the underly lytic less m in ly	/	23e. Did tobacco	. 1	the cause of death?
COPD CA	na D, PVD		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?			h (Check only one)		
1 ☐ Yes 2 No		□ DOA Other: 4 □ Nursing Ho	ome 5 Residence	6 □Other (Spe	city)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe how inju		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Sta		ural Route Number,
29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my knowledge, death occurrence: On the basis of examination and/or investigand manner stated.	rred at the time, date and place, ation, in my opinion, death occur	and due to the cause(red at the time, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier	uD.	29c. License number		log/20	
	mpleted cause of death (Item 23a) (Type, Print)		1229 5	t. Agres	Health care.

State Registrar

DHMH 17 Rev 1/2001



ZHU , Zejin

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Man		artment of H tificate of L			giene Reg. No.	12244
	Physici /Medic		1. Decedent's Name (First, Middle, Las	MCQU	1 ade			2. Date of Dea Month	Day Year	P 6.301W
	Examin	ier	4a. Facility Name (If not institution, give Ellicott City Nur	sing Home		Ellic	Location of Death		4c. County of De	ath
	Funeral Director		5. Social Security Number 6. Security Number 284-12-8381 Usual Residence of Decedent	TM 2ME	n yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7/9/1	r, Year) C	irthplace (State or Foreign Country) :10
	Maryland -f show	tor	10a. State 10b. County MD Howard	10	c. City, Town or Lo	cation Ellicoti	r City			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Director	10e. Street and Number 3355 North Chathar	m Rd. Apt.	ī	10f. Zip Code	042		10g. Citizen of What C	Country?
336	be filed within 72 hours after death with the Maryland at Hygiene. A thy selection of the than "natural", or frams 23a or 28a-f show other than "natural", or frams 23a or 28a-f show event, the Medical Exacili et must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13. \	Vas Decedent of Hi Yes, specify Cuba		pecify Yes or No- Rican, etc.)		
21215-0036	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of work ()	sing	16b. Kind of Business	s/Industry
Maryland 2	ed fa d	To Be Co	17. Father's Name (First, Middle, Last) Demetro Bilica	Service		Homemal			Own Hom Maiden Sumame)	e
	as 1 and 2 should of Health and Men I itam 27 is marka r other traumatic		19a. Informant's Name/Relationship (7 Carol Lynch - Dau	ghter	13 Mo	ckingbir	d La. Was	hington	r, City or Town, State,	10992
Baltimore,	Pages ment of ant: If ury or		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License	Removal from State	Metro Cre	natory or other plac matory	θ) 4/18	3/2006	Catonsvil	le, MD
Ba	Departr Departr Importa any inji		Bernand	Dalno	Secret Ed	mondson /	Ave. Cat	onsvill	shton-Schwe, Inc. 16 e, MD 2122	
	nysician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a co	clerotu	Carol	en Van Cl	ila 1	Pipase	Interval Between Onset and Death
	cate be executed why sicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
.O. Box 68	ne death certific the attending p thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Δ.	es be	by	Part II. Other significant conditions co	ontributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.		bacco use contribute tes 2 □ No 3 □ F	to the cause of death?
Il Records,	The ate ha	Completed						24a. Was a autops perform	sy prior to death?	autopsy findings available completion of cause of s 2 \(\text{No} \)
	Attending Physician: Th r death. actor: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	at	me 5 Reside	ne) ence 6 □Other (<i>Spi</i> ow injury occurred	ecify)
Divis	ha Hospital or Attending Phys n 24 hours after death. ha Funaral Diractor: After this pletely filled in by the funeral di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by	fedical	(Check only 2 Medical Exam	ysician: To the best of m iner: On the basis of ex- and manner stated	amination and/or inv	estigation, in my op	oinion, death occur	red at the time, d	late and place, and du	ue to the cause(s)
	T with	Σ	29b. Signature and title of certifier	lu		29c. License			April 1	th, Day, Year) 4 2006
	3		30 Name and address of person who co Ramerh Sab	apalhi		Print) Isack 1	leir, Ne	culton	ol Baltinu	& Maylas Zieri
	Sta Registr		31. Date filed (Month, Pay, Year) 9 2	006 32. Registrar's	Signaturo	andi				V

			For State Registrar	State of Maryland		artment of F			2000	12245
			Registrar 1. Decedent's Name (First, Middle, Last)		001	tineate of	Douin	2. Date of Death	g. No.	3. Time of Death
	Physicia	an	and the same of th					Month	Day Year	
	/Medic		Deanne		900			4	14 06	4:05p M
}	Examin	er	4a. Facility Name (If not institution, give st	treet and number)			r Location of Death		4c. County of Dea	
			Charlestown Care Co			Catons		1 - 2	Baltimore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)
	Director	}	217-09-0807 Usual Residence of Decedent	91	113.			April 20	$1914 \mid \text{Wes}$	st Virginia
	and w	}	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Aaryi Feho	ō	Maryland Baltimore	Cat	onsvil	le				1 ☐ Yes 2 🛣 No
	28a-	Directo	10e, Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	with		717 Maiden Choice	Tana C+a 201		21228			USA	,
	eath	era		2. Was Decedent Ever in U.S	3 13 1				14. Race - Ame	arican Indian
	lterr	Funeral	1 Never Married 2 Married	Armed Forces?	3. 10.	If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Whit	te, etc.
99	filed within 72 hours after death with the Maryland Hygiene. Ither than "neturel", or terme 23e or 28e-f ehow ent, the Medical Examiner must be notified at	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh	nite
Ş	ture eal E	ed	15. Decedent's Educ		16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business	/Industry
<u> </u>	n 7	ple	(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most of world)	king		
7	with jene r tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Cler	k			Insurance	j
ਰੂ	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
Maryland 21215-0036	lenta fenta rked ric e	To B	Harvey L. Meese				Minnie E	. Heinba	ugh	
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Items 72 is marked other than "naturel; or Items 23a or 28a-f show arry injury or other treumatic event, the Macical Exemitive must be rediffied at once.		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	rai Route Number,	City or Town, State, .	Zip Code)
Σ	alth a		Evans A. Mezger	Son	1117	General	George Pa	tton Rd.	: Nashvill	Le TN 37221
ē,	tem of He other		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of matory or other pla	ce)		0c. Location - City or	
Baltimore,	Page sent c nt: If ry or		1 ØBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			1	3/2006 E	lkridge, N	Maryland
<u>=</u>	mit.		21. Signatur meral Service Livense						hton Schwa	
m	E E E E		Maple) MO12	290 1	uneral H	ome of Ca dson Aver	itonsvill Due: Cato	e,1nc. nsville, N	m 21228
			23a. Part1. Enter the disease, or complic	cations that caused the death						Approximate Interval Between
	Physician		shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	, =	/	a			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of the consequence of t	ience of):	a) jur				
	Examiner			Congen	twe	Heart	+ Fail	4 +0		
٠,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):					
V	outed id ansit	Examiner	Cause (Disease or injury that initiated events	Critical	Acr.	tie Ste	rosis			
0	te be executed ysicien and le burial-transit		resulting in death) Last	Due to (or as a consequ	ence of):					
,092		cal	L d.							
68		Jed	IF FEMALE:							
Вох	th ce rendi	an/	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnate 1 Live birth 2 Fetal		Ectopic pregnanc	v		23d. Date of de Month	livery Day Year
	ed fo	SCI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)			Worth	Day 1 Gai
<u>Ф</u> .	at the by the stach	by Physician/M	9 ☐ Unknown						The second second second	
	es that the death certific igned by the attending p be detached for use as		Part II. Other significant conditions con-						acco use contribute to	
ב	w requir been si should	ted	Parkinsm's					1 L Ye:	s 2 □No 3 □ P	robably 4 dhknown
ပ္ပ	law r as be 2 sh	ple	Hyperten	sion				24a. Was an autopsy		utopsy findings available completion of cause of
<u> </u>	The ate h page	Completed	/ ·					perform	ed? death?	2 □ No
Division of Vital Records,	ician: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?					th (Check only one)	
<u></u>	Physic this ce al dire	္	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 1	EP/Outpatier	nt 3□ DOA Ott	ner: 4 Nursing H	ome 5 Resider	nce 6 Other (Spe	ecify)
0	ding PI After ti funera		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju	ry at rk?	28d. Describe how	w injury occurred	
.0	and:	Centification:	2 Accident investigation			M 1]Yes 2□No			
Š	I or Attendation designation of the designation of	ij.	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	the Hospital or hin 24 hours affe the Funeral Dir npletely filled in									
	Hosp 4 hou Fune ely fil	Cal	(Check only 2 Medical Examin	sician: To the best of my knowner: On the basis of examinat	wledge, deat	h occurred at the ti	me, date and place opinion, death occu-	, and due to the ca rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	and manner stated.						
	To Too		29b. Signature and title of certifier	0		29c. Licens			d. Date signed (Mon.	
į.	1		Kleven Bos	whi , me	0	DY	4377	2	114106	
	10		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type,	Print)		0 0:	11 -	4. 0.01
	W		31. Date filed (Month, Day, Year)	MIN 7-11 1	regal	en choi	ce Lui	ne, Cata	nsville,	MD 21328
	Sta Registi		APR 1 9	mpleted cause of death (Item , mb 711 N 32. Registrar's Signar	K	Coordi				
				T. STILLING F RC MT STILLINGS		- 75				

		1 - For State Registrar	State of Maryland		ent of Health and ate of Death	Mental H	ygiene Reg. No.	006	12246
		Decedent's Name (First, Middle, Last)				2. Date of D		Vane	3. Time of Death
Physic		ELMER E	EUGENE	McD	ONALD	APRIL	L 14		6:05 AM
/Medi Exami		4a. Facility Name (If not institution, give stre			ty, Town, or Location of Deat	th	4c.	County of Death	
		FUTURE CARE	JURSING HOI	ME	ARNOL	0	1	INNE ARI	NDEL CO.
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) If Un	der 1 Year If Under 24 Hrs		irth	9. Birthp	lace (State or Foreign
Director		220-22-805/	120F 78	Yrs.	lo bayo moule	SEPT.	04.1	927 MA	RYLAND
pu 🔪 🗆		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location					Od. Inside City Limits
anyla sho	5		0	TOWN OF EGGATION	-1 - 1 A.			'	1 ☐ Yes 2 ₹ No
he M Sa-f	ecto	MARYLAND ANNE ARUN	DELCO			RNIE	10- 04		
with t	5	10e. Street and Number	11.10- Ray	11. PA	Zip Code	^	Tog. Citi	izen of What Coun	ury r
s 23	Funeral Director	1910 E. PURI	Was Decedent Ever in U.S.	12 Was Do	and ant of Hispania Origin? (9	Coordy Voc or N	10-	14. Race - Americ	an Indian
lter d	Š	11. Marital Status 12. 1 ★ Never Married 2 ☐ Married	Armed Forces?	If Yes, s	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puer	to Rican, etc.)		Black, White,	
irs af	by	3 □ Widowed 4 □ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:			Specify: 13/	AC.K
72-0000 n 72 hours after death with the Manylar "natural", or Items 23s or 28s-1 show salcal Exercited must be notified at		15. Decedent's Educat		16a. Decedent's U	sual Occupation	74	16b. Ki	nd of Business/Inc	dustry
nin 7.	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4or 5+)	life. DO NO	•	rking			
d with	E	4	YR5	TE.	ACHER		ANI	VE ARUNDA	EL PUBLIC SCHOOL
S S S S S S S S S S S S S S S S S S S	Be	17. Father's Name (First, Middle, Last)	1		18. Mother's Na	me (First, Midd	le, Maiden	Sumame)	
ally failed A IA I O'COOO should be filed within 72 hours after death with the Manyland ad Mental Hygiene. I marked other then "natural", or items 23s or 28s-f show umatic event, if a Medical Evaruing must be notified at	10E	WILLIAM HE.	NRY MCD.	ONALD	MAU	DE E	LS10	E COL	LE
2 should be filed with and Mental Hygiene. Is marked other the sumatic event, Iran		19a. Informant's Name/Relationship (Type			ess (Street and Number or R	ural Route Num	ber, City o	r Town, State, Zip	Code)
ie, intal ylalid ZIZIOOOO		HILDA DORSEY	(SISTER)	73196	OTSON LA.	GLEN	BUR	NIE, MD	21060
O H O H		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Rem	cen	ce of Disposition (/ netery, crematory o		Date	20c. Lo	cation City or To	wn, State
permit. Pages : Department of Himportant: if Ite any Injury or ot once.		4 Donagion 5 Other (Specify)		WNSVIL	ECEME 04.	21-06	CRO	WNSVIL	LE, MD
permit. Pa permit. Pa Departmer Important any Injury		21. Signature of Funeral Service Libensee	12	22. Name	and Address of Facility	BROWN	JR.	FUNERI	4L HOME
2 82 5 8		PUX D-	1,000	214	ON FULTOR	AVE.	BAL	TO. HO	21217
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. cause on each line.	Do not enter the m	node of dying, such as cardia	c or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	CEREBRON	ASCUL	AR DISER	SE			Onset and Death
/Medical		resulting in death)	Due to (or as a conseque						
Examiner		Sequentially list conditions, b							
D =	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):				l l	
acute ind trans	am	that initiated events c. resulting in death) Last							
e exc sien g urial-	<u>G</u>	resulting in doutily East	Due to (or as a conseque	nce of):					
cate be executed physicien and the burial-transit	dical	d							
wrequires that the death certific been signed by the attending F should be deteched for use as		IF FEMALE:	. If yes, outcome of pregnance						
ath c attend	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d	eath 3 Ectopic	pregnancy		1	23d. Date of delive Month	ny Day Year
the d	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	th 5 🗌 Other	(ѕреспу)				
hat the detection		Part II. Other significant conditions contin	buting to death but not resulti	ing in the underlyin	g cause given in Part I.	23e. Dio	I tobacco u	se contribute to th	e cause of death?
sign, d be	1 by			,		10	Yes 2	□No 3□ Prob	ably 4 Nnknown
requir been si should	Completed							1	
e faw hes l	mpi					24a. We	is an opsy formed?	prior to cor death?	psy findings available npletion of cause of
n: Th icete r, pag						1□ Yes	2000	1 ☐ Yes	2□ No
VILGI sician: certifice rector, p	Be	25. Was case referred to medical examiner?	pital:		26. Place of De				
Phys ral di	.T	10 163 2010	1 _ Inpatient 2 _ E	R/Outpatient 3 8b. Time of	DUA 4 PANUrsing I	Home 5 Re 28d. Describe		6 Other (Specify	/)
ding After fune	tion	1 Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Doscribe	5 110 W 111Jus	y cocurrou	
Attending Phy ar death. •ctor: After thi by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom			28f. Location	(Street an	d Number or Rura	I Route Number
lin by	erti	4 ☐ Homicide determined	building, etc. (Specify)	10, 14111, 3(1001, 120	cory, onico		own, State		Triodio Trambol,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	C	29a. Certifier 1 Certifying Physic	ian: To the best of my knowle	edge, death occurr	ed at the time, date and place	e, and due to th	e cause(s)	and manner as st	ated.
24 h 24 h Fur etely	edical	(Check only 2 Medical Examine one)	r: On the basis of examinatio and manner stated.	n and/or investigat	ion, in my opinion, death occ	urred at the time	e, date and	place, and due to	the cause(s)
orthin orthin compl	₹	29b. Signature and title of certifier			29c. License number		29d. Dat	e signed (Month,	Day, Year)
->-0		Menegi. M	4.5		D57531		APR	11 14 X	2006
54		30. Name and address of person who com	pleted cause of death (Item 2	23a) (Type, Print)					
9		Mohit Negi 8601	Veterans Hu	sy, sull	= 204, Mill.	ersvil	le,	MD 2	1108
s s	ate	30. Name and address experson who com Mohi Wegi, 86 01 31. Date filed (Month, bay, Year)	32. Registrar's Signatur	ге	,	-			
Regist		1001 0 0000	A .						

ORIGINAL

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orraine Mary M		1- For State Registrar	State of Mary		partment ertificate		d Ment		Reg	No. 20	J6 2	24
Physicia Medical Exami		Decedent's Name (First, M						Mo		ay Year	3 Time of Dea	
vieuicai Exami		Lorraine M 4a. Facility Name (if not instit				4b. City, Town, or	Location o		ril 16, 200	4c County of		,
		St. Agnes Hospital	, 3	,		Baltimore				n/		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)		_	_	ate of Birth(Birthplace (State of Foreign	
Director		214-64-6058	1 M 2 X F	52	2	Yrs. Months Day	s Hours	Min. 0	8/26/	1953	Country) Mary	<i>y</i> land
'n	ļ	Usual Residence of Deceder 10a. State 10b. Cou		10c Ci	ity, Town or Lo	cation					10d. Inside Ci	ity Limite
ow any			e Arundel	1	Linthio						1 Yes 2	
Maryland 28a-f show 1 at once,	향	10e. Street and Number				10f. Zip Code	_		10g.	Citizen of What	t Country?	
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	Director	462 Susan Cou	rt			210	90			USZ	\boldsymbol{P}	
with ms 23.	eral	11. Marital Status		ecedent Ever in Forces?		Was Decedent of His If Yes, specify Cubar				14. Race - White,	American Indian, Bla	ack,
or ite	Funeral	1 Never Married 2 X	1 Yes	2 X No				T donto Trican	, 0.0.7			
rs afte ural", miner	à	3 Widowed 4 15. Decedent's Education (Divorced If Yes, Give Y or Dates: Specify only highest or		16a. Dece	Yes 2 X No		ind of work de	one 11	Specify: 6b. Kind of Busin	White ness/Industry	
72 hou n "nat	ee	Elementary/Secondary (0-		(1-4 or 5+)		g most of working life	. DO NOT I	use retired)			,	
5-0036 led within 72 hours at tygiene other than "natural the Medical Examin	Completed	10		0	Hor	memaker				Own Hor	ne	
		17. Father's Name (First, Mic Edward Campio						s Name (First, Alberta		den Surname) a oli s		
2121: uld be fil Mental P marked c event,		19a. Informant's Name/Relati	and the second state of the second		19b. Mai	iling Address (Stree					State, Zip Code)	
e, MD I and 2 sho Health and item 27 is		Frank Paul Ma	riano			Susan Cou						
nore, MD 2 Pages I and 2 shouldent of Health and M nnt: If item 27 is m		20a. Method of Disposition	ation 3 Removal	I		position (Name of ce other place)	metery,	Date	2	20c. Location - C	City or Town, State	
Pages Pages nent o ant: I	- 1	4 Donation 5 V Othe			oudon I	Park Cemet	ery	4/21/2			re, Maryla	and
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr		21. Si nature of Funeral Ser	vice Licensee		22	2. Name and Addres	s of Facility	Hubbar	d Fund	eral Hor	ne, Inc.	
Physician	-	23a. Part I. Enter the disease	e, or complications that	caused the dea							aryland 21 Approximate	
/Medical		failure. List only one ca	use on each line.			, ,		·			Between Or Deat	
xaminer		Immediate Cause (Final dise or condition resulting in deat		a consequence								
Mr	_	Sequentially list conditions, if any, leading to immediate	b.	a consequence	a of):							
	nine	cause. Enter Underlying Ca	use	a consequence	- 01).	38. 38.			G(3)			
ed nsit	Examiner	events resulting in death) La	ast Due to (or as	a consequence	e of):							
68760, certificate be executed nding physician and ise as the burial - transit	fedical	Xunpended	d. X AMENDED	item#2	3a,27,28	a-f,perME,g8	855 , 5/1	/06 TT				
60, ate be ex obysician the burial	Med	IF FEMALE	23c. If yes	item#4 s, outcome of pr	egnancy	rME_e855_5/	5/06 T	Γ		23d. Date of de	elivery	
Box 68760 e death certificate be the attending physical for use as the bu	sician/N	23b. Was decedent pregnant past 12 months?	in the 1 Live	birth gnant at time of	2	Fetal death 3	Ectopic	pregnancy		Month	Day Y	rear .
30x death c e atter	ysic	1 Yes 2 No 9 🗸	Unknown	nown	death 5	Other (Specify)						
that the d ted by the	/ Phy	Part II. Other significant co	nditions contributing	to death but no	ot resulting in th	ne underlying cause	given in Pa	rt I. 2	23e. Did toba	cco use contribu	ute to the cause of de	eath?
b, P.O. ires that the signed by the detacl	d by							\	1 Yes	2 V No 3	Probably 4 Ur	nknown
ords, w requir s been s should 1	olete							2	24a. Was an autopsy	pri	ere autopsy findings a or to completion of ca	
Reco	Completed							1	performe ✓ Yes 2		ath? ✓ Yes 2	No
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternopletely filled in by the funeral director, page 2 should be detached for u	Be	25. Was case referred to me examiner?	dical Hospital:				of Death (Check only or				
f Vi Physic er this	ပ္	1 Yes 2 No 27. Manner of Death	1	Inpatient 2 te of Injury	✓ ER/Outpati 28b. Time		iry at Work	Nursing Hon			Other: Driver of a	
ion of V tending Phy eath. for: After th	io.	1 Natural 5	(Moi	nth, Day,Year)			Yes 2 X			guardrai		1ULO
risic r Atter er dea irector	licat	2 X Accident	Investigation APL 1.	1 16, 200 ace of Injury - A		treet, factory, office					or Rural Route Num	ber, City
Divis pital or At ours after d eral Direc filled in by	Certification:	Odicide	determined (Specif	y) Highw	ay 			Will Will	or Town, Stat Cins Ave	e. Baltimo	loop I-695 n ore, MD	iear
e Hosy 124 ho e Fund etely i		(Circuit Cirily	ng Physician: To the b					ce, and due to	o the cause(s	s) and manner a	s started.	
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical 29b. Signature and title of ce	Examiner: On the basi and manne		n and/or invest	29c, Licen		curred at the t				
	2	29b. Signature and title of ce) - 7	10		O.C.				April 17, 200	(Month, Day, Year)	
		30. Name and address of pe	rson who completed ca	use of death (It	em 23a)					, 200		
01			Assistant Medica	-		n Street, Baltim	ore, MD	21201				
	tate	31. Date filed (Month, Day, Yo		Registrar's Sign	nature &	1.1.						
Regis		; ATR	1_9_2006[A BURNES	A. A.	73514 BL						
DHMH 17 Rev 1/2 OCME 2006	2001	サカンラン	2007		RIGII	NAL						

MAY 2 7 2007

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Amend item 31 per dvr 9854 4-19-06 vt

State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 April 12, Year **Physician** Stefanie Molnar 1:45 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford 1317 Ipswich Drive Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🗙 F Yrs. 25, 1949 Pennsylvania Director 135-44-3552 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location s 23a or 28e-f show 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1317 Ipswich Drive 21014 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status r then "natural", or Items The Madical Exercitive to Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: If item 27 is marked other the any injury or other traumatic avent, ITA DRS. Claims Examiner Health Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elizabeth (nmn) Goetter Krasowsky Stephen (nmn) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1317 Ipswich Drive, Bel Air, MD 21014 Steve Molnar / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3∑ Removal from State St. Johns' Luth. Cem. 4-15-06 4 ☐ Donation 5 ☐ Other (Specify) Williamstown, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complishock, or heart failure. List only or eaties that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, no bause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initroclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner JIVISION OT VITAI HECORDS, P.O. BOX 6876U, contracting Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARCINOM 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Director: After Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) completely To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Stanature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) RD, JUHA, TALLSTON MD 21047 EDWARDS 31. Date filed (Month, Day, AD) 2006 Segistratis Signature 9

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 rem 1 per doc 8554 4-19-06 reb State of Maryland 7 Department of Health and Mental Hygiene | | | | | | 1 - For Stata Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6: 05 PM MossJennifer 2006 Apri 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hopkins Hospital Johns If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 XF Yrs. 625-09-0210 Director Aug. 25, 1982 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. and them 23 or 28e-f ehow ant: If Item 27 te marked other than "natural", or Iteme 23e or 28e-f ehow 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes & No Completed by Funeral Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11640 Little Patuxent Parkway 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense 4 Linquist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Ronald Kowalsky Patricia Anne Lebo ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth of Heelth other tra 1205 Waterford Court, Bel Air, Maryland 21015 Christopher R. Moss / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ot ance. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4-14-06 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. Kenling 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Hemorrhage
Due to (or as a consequence of): **Physician** disease or condition resulting in death) week /Medical Examiner Acute Myelsi'd

Due to (or as a consequence): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be del 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 V No infarct with hemorrhagiz conversion ormed? 2 ☑ No certificate 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours efter death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and direct the nause(s) and manner at stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kheled el Skam - Fellow RES-000 4/11/2006 Khales El Shami 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johnstopkins Hospital, 600 N. Welfe Street, Boltimore

OFLIGINAL

32 Aegistrar's Signature

Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1 9

2006

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

		1	For Stata Registrer	State o	of Maryland		rtment of H		Mental Hygi	ene 006	12250
	Physicia		Decedent's Name (First, Middle DELORES)		MITCHEI	LL			2. Date of Death Month 4 / 12 / 0	Day Ye	3. Time of Death 6:30 P M
	/Medic Examin		4a. Facility Name (If not instituti				4b. City, Town, or	r Location of Deat		4c. County of D	
	LAGITITI			3000 Toward	a Avenue		BALTI				N/A
	Funeral Director		5. Social Security Number 215-34-8986	6. Sex 1 ☐ M 2 ½ ☐ F	7. Age (In yrs. le	st birthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) Maryland
	D	<u> </u>	Usual Residence of Decedent 10a. State 10b. Coun	tv	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho		Marvland	N/A				altimore			1 X Yes 2 □ No
	the N	rect	10e. Street and Number				10f. Zip Code		10	og. Citizen of Wha	t Country?
	h with	a D	3000 Towanda Ave	enue - #102				21215		U	J.S.A.
36	is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene. If marked other than "neturel", or Items 23a or 28a-f show other traumatic event, the Medical Examinet must be inclified at	by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 W Widowed 4 Divorce	Armed Farried 1 Tyes	2 No		Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, Vhite, etc. Black
0	ture!	ed b		ent's Education	Jates.	16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	
5.	nin 72 '' nin Wedic	plet		nest grade completed,	1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo	orking	Glass	s Company
21215-0036	ad with	Completed	12	, conege (Skille	d Worker			
Maryland	be file tal Hy d oth event	Be	17. Father's Name (First, Middle					18. Mother's Na	me (First, Middle, M	Maiden Sumame) Ambrose	
<u>≯</u>	narke narke	၉	JO 19a. Informant's Name/Relatio	hn Ambrose		10h Mailie	a Address (Street	and Number or P	ural Route Number,		te. Zin Codel
<u>a</u>	d 2 sł th and th and t7 le n traun	1	ELVA LE				EBERLE		LTO. MD		(APT 202)
<u>ق</u>	Heal Heal tem 2		20a. Method of Disposition		20b. P	ace of Dispo	sition (Name of natory or other place	1		20c. Location - City	
E E	Pages nent of I ant: If ite ary or o		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other		State		rection Cem		04/18/06	Clintor	n, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service	ce Licensee	steps	The second second	Name and Addre ESTE	ss of Facility P BROS.	FUNERAL PL. BALTO	L HOME	P.A. 21217
	cate be executed / Medical Examiner Control of the purial-transit Control of the purial-tr	dlcal Examiner	23a. Part1. Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence of or a consequence or a consequence of or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a	lence of):	Lestin	a (Block	ling_	Approximate Interval Between Onset and Death
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Ś	S 00 0	by	Part II. Other significant cond	itions contributing to	death but not rest	ulting in the u	nderlying cause giv	ren in Part I.		acco use contribu es 2□No 3□	te to the cause of death? Probably 4 Donknown
o C	e law has b	ompleted							24a. Was ar autops perform	y prior deat	e autopsy findings available r to completion of cause of th? Yes 2 100
ita I	yeicien: Th is certificate director, pag	Be C	25. Was case referred to medi examiner?						eath (Check only one	e)	
of V	N SI	P	1 Yes 2 □ No			ER/Outpatier	1 3 DON		Home 5 Reside		Specify)
드	ing P	lon:	27. Manner of Death 1 Natural 5 ☐ Pen	uliig .	nth, Day Year)	28b. Time o Injury	Wor	ryat rk? Yes 2 □ No	28d. Describe no	w injury occurred	
=	spitel or Attending Phours after death. verel Director: After the filled in by the funeral	Certification:	3 Suicide 6 □ Cou	rmined 200. Flat	e of Injury - At ho ding, etc. (Specify	me, farm, str	eet, factory, office	103 2 110	28f. Location (Sti City or Town		or Rural Route Number,
F	한다고등	edical C	29a. Certifier 1 ✓ Certifier (Check only one)	ying Physician: To the let Exeminer: On the and ma	e best of my kno basis of examina nner stated.	wledge, deat tion and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
).	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certi	fier teu	PU	(a)	29c. Licens	se number (4626=	2	9d. Date signed (A 4/14/0	Month, Day, Year)
•	3		30. Name and address of pers J. Boater	on who completed car	use of death (Item)23a) (Type,	Print) (vedere	Ave.	Baltine	or wis	0 UU5
ŀ	Sta Regist		31. Date filed (Month, Day, Ye APR 1	9 2006 32.	egistrar's Signa	ture	all!				

	1 - For State Registrar	Mental Hygie	ygiene Reg. No. 006 225						
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year April 16 2006 8:45 AM M								
/Medical Examiner	James Edward Metts 4a. Facility Name (If not institution, give street and	April 16	4c. County of Death						
Lxamilier	3506 Parkside Drive		Baltimore	9	Baltimore City				
Funeral	5. Social Security Number 6. Sex	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Y	9. Birthplace (State or Foreign Country)					
Director	216-52-2269 Usual Residence of Decedent	55 Yrs.		12/12/19	950 NY				
yland	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits				
death with the Maryland ms 23e or 28e-1 show rever to notified at reral Director	MD Baltimore Cit	y Baltimore)		1 □ X es 2 □ No				
or 26	10e. Street and Number 10f. Zip Code				. Citizen of What Country?				
auth v	3506 Parkside Drive	Decedent Ever in U.S. 13.	21214 Was Decedent of Hispanic Origin? (S		nited States 14. Race - American Indian,				
<u>a</u> 2 3 .5	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married	Forces? es 2 □ No Give	was becedent of Hispanic Origin? (3 if Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ⊠No <i>Specify:</i>	o Rican, etc.)	Black, White, etc. Specify: Black				
hours fursal ed b	15. Decedent's Education	or Dates: 1971-1974	dent's Usual Occupation	16	b. Kind of Business/industry				
21215-06 ed within 72 hos ygiene. her then "natura t, the Medical	(Specify only highest grade complete	ed) (Give	kind of work done during most of wor DO NOT use retired)	rkina	edical				
2121 d within giene. or then	Elementary/Secondary (0-12) Colleg	se (1-4or 5+) 5+ Socia	l Worker	Re	ehabilitation				
Maryland 21215-0036 at 2 should be filed within 72 hours alf this and Markal Hygiens, or 77 is marked other than "natural", or treumatic event, the Marical Exert To Be Completed by F	17. Father's Name (First, Middle, Last) James Metts			ne (First, Middle, Ma. fae McConne					
ryla hould d Men marke matic	19a. Informant's Name/Relationship (Type, Print)	19b Maili	ng Address (Street and Number or Ru						
Ma 2 s alth an 2 27 Is r treu	Mrs. Vesheara A. Nutter-								
s 1 ar if Hea other	20a. Method of Disposition	20b. Place of Dispo		Date 20	c. Location - City or Town, State				
Pages nent of anti-	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State	ke Crematory	Apr 18 2006 Be	eltsville, Maryland				
Baltimore, permit. Pages 1 at Department of Hea Importent: If New any Injury or othe once.	21. Signature of Funeral Service Licensee		2. Name and Address of Facility remation and Funera 71/ Green Pastures						
ASSESSED AND ADDRESS OF THE PARTY OF THE PAR	23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at cause the death. Do not en			STREET, DOLLARS CONTROL OF THE STREET, THE STREET, THE STREET, THE STREET, THE STREET, THE STREET, THE STREET,				
B760, cate be executed by sicien and the burial-transit dical Examiner	Socientially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or as a consequence of):	Confor	nezt (Onset and Death				
Box 6i ath certific titending p or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Un		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
ds, P.O. I uptices that the de signed by the a lid be detached for the both by the control of by Physic	Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ☑ Triknown				
Vital Records, elicien: The law requires to certificate has been signe rector, page 2 should be completed by				24a. Was an autopsy performer	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 22 No				
f Vital F yeicien: Th is certificate director, pag	25. Was case referred to medical examiner?			ath (Check only one)					
His his	1 ☐ Yes 2 ☐ No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatient ate of Injury 28b. Time of							
on of ding Ph. After thi tuneral	27. Manner of Death 28a. Date 1 ☑ Natural 5 ☐ Pending	28d. Describe how	8d. Describe how injury occurred						
Division of lor Attending Phy after death. Director: After this in by the tuneral dertification: Treertification: ccident investigation 3 Suicide 6 Could not be	28f Location (Street	et and Number or Rural Route Number.							
Division cells or attending P is after death. el Director: Attert ed in by the funera	4 Homicide determined 286. Fi	lace of Injury - At home, farm, st uilding, etc. <i>(Specify)</i>	eet, ractory, office	City or Town, S	City or Town, State)				
Hospi 14 hou Funer tely fill	29a. Certifier (Check only one)	the best of my knowledge, deat the basis of examination and or in nagner stated.	occurred at the time, date and place vestigation, in my opinion, death occurred	and due to the caus irred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)				
To the within 2 To the comple	29b. Signature and title of certifier		29c. License number	/ 29d	. Date signed (Month, Day, Year)				
			167721	5 4	17-06				
414	30. Name and address of person the completed of	1	Print) Dr. #411 10	uson, Mi	21204				
State		2. Registrar's Signature	Rogades		- I				

JAMES EDWARD MRITS 4/16/06

		State Registrar 1. Decedent's Name (First, Midde	dle. Last)		Certi	ficate of D	eatn	Re 2. Date of Death	g. No.	3. Time of Death	
Physicia		Peggie - MEDLEY						APRIL	Day Yea	1 9. A.A.	
/Medica	_	4a. Facility Name (If not institution			4	b. City, Town, or Lo	ocation of Death	11171	4c. County of De	30 1	
LAdilline	Ç1	Howard County				Columbi			Howard		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.			f Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)	
irector		219-20-6922	1 □ M 2 🖫 F	80	Yrs.	onths Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 18	, 1926 V	irginia	
		Usual Residence of Decedent 10a. State 10b. Count		10- 6	T						
me 23a or 28e-f ehow ir must be notified at	5				y, Town or Locat	on				10d. Inside City Limits	
	by Funeral Director	MD Howard Laurel 10e. Street and Number 10f. Zip Code							022	1 ☐ Yes 2 ☐ No	
3	ᡖ		- p:::			10f. Zip Code		10	g. Citizen of What	Country?	
	era	9396 Canterbur		edent Ever in U	S 13 Wa	20723		ofu Voc or No	U.S.A.	merican Indian,	
	ᇤ	1 ☐ Never Married 2 ☐ Ma	Armed Fo	orces?	If Y	Decedent of Hisp es, specify Cuban,	Mexican, Puerto I	Rican, etc.)	Black, W	hite, etc.	
	þ	3 ☐ Widowed 4X Divorce	If Yes Gi	ive	1 🗆	Yes 2XXNo	Specify:		Specify: W	hite	
8	Completed	15. Decede	nt's Education		16a. Deceden	's Usual Occupation	on	1	6b. Kind of Busines	ss/industry	
in tall H	ple	(Specify only night Elementary/Secondary (0-12)	est grade completed) College ((Give kin life. DO	t's Usual Occupation of work done dur NOT use retired)	ring most of workii	ng		,	
	200		3 year		Secreta	ary / boo	kkeeper	τ	J.S. Gove	rnment	
	Be (17. Father's Name (First, Middle	, Last)			18	8. Mother's Name	(First, Middle, M	laiden Sumame)		
	2	Richard C. Tay	lor				White F				
		19a. Informant's Name/Relation							City or Town, State		
		Nancilee Medle	y / daug	hter	_			-	l, Maryla		
		20a. Method of Disposition 1 ☐ Burial 2 XX remation	3 □Removal from	State 20b. F	Place of Disposition of the Place of Disposition of the Place of Disposition of the Place of the	on (Name of ory or other place)	į D	ate 2	Oc. Location - City	or Town, State	
		4 ☐Donation 5 ☐ Other (st Arund	del Crem.	4/17/	2006	Odenton,	Maryland	
DC D		21. Signature of Funeral Service	/		22. N DC1	am and Address	f Facility uneral H	lome, P.A	A. Marylan	55 XX 2707 CC3	
ē ol		(france)	- Local	0160						d 20707	
8		Part1. Enter the disease, of shock, or heart failure. List	or complications that of the confidence on the confidence of the confidence on the c	caused the deat each line.	h. Do not enter t	ne mode of dying,	such as cardiac o	respiratory arres	st,	Approximate Interval Between	
hysician		Immediate Cause (Final disease or condition ACLITE RENIAL FAILURE								Onset and Death	
ical ner		resulting in death)		(or as a conseq	uence of):						
	_	Esquentially list conditions,			PNEUL	A ino				one was	
ed by the attending physicien and detached for use as the burial-transit	ine	E squantiarly liest conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events c.									
	Examiner	that initiated events resulting in death) Last	C. Due to	(or as a conseq	uanca of):						
	caiE		, Dualo	(01 43 4 0011364	derice or).					1	
:			d								
80	Me	IF FEMALE:	23c. If yes ou	tcome of pregna	incv				1/21/		
	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	birth 2 ☐ Feta nant at time of d	Ideath 3 □Ec	opic pregnancy her (specify)			23d. Date of d Month	Day Year	
1	ysi	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unkn		Jun. 3 🗆 0	ner (speeny)					
de1a	g V	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did toba	acco use contribute	to the cause of death?	
w requir been sl should		SENILE DEMENTIA						1 Yes 2 No 3 Probably 4 Unknown			
	ete	DCTP = A	ROHRITI	0							
	E C	03/20 1	FORK III					24a. Was an autopsy performe			
	ပိ	25. Was case referred to medic	n1					1 Yes 21	№ No 1 🗆 Y	es 2 No	
<u> </u>	ă	examiner?	6. Place of Death								
										oecity)	
aral director,	္	27. Manger of Death	ing (Mon	1 Ø Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be determined of termined.				,,			
funeral director.	္	1 Natural 5 ☐ Pend					eet, factory, office 28f.		ff. Location (Street and Number or Rural Route Number,		
by the funeral director.	္	1 Natural 5 ☐ Penda 2 ☐ Accident invest 3 ☐ Suicide 6 ☐ Could	not be 28e. Place	or injury - At no	()				Town, State)		
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y illied in by the luneral director.	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a Certifier 1 Certifyi	I not be nined 28e. Place build	ing, etc. (Specif	wiadna diath is	curried at the time.	date and place, a	nd dua to the cau	usu(s) and manner	às statad	
	Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a Certifier 1 Certifyi	and be a see Place build a see	ing, etc. (Specif	wiadna diath is	curred at the time, gation, in my opini	date and place, a ion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner e and place, and d	us stated. ue to the cause(s)	
	္	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Certify 2 Medica	I not be mined 28e. Place build 28e. Place build 1999 1999 1999 1999 1999 1999 1999 19	ing, etc. (Specified best of my knowns	wiadna diath is	29c. License n	on, death occurre umber	d at the time, dat	d. Date signed (Mo	ue to the cause(s)	
al director	edical Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	I not be 28e. Place build in J Physician: To the I Examiner: On the band man	e best of my knopasis of examina ner stated.	wiadge death or tion and/or invest	29c. License n	umber	d at the time, dat	d. Date signed (Mo	nth, Day, Year)	
pletely filled in by the funeral director	edical Certification; To	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifyi	I not be 28e. Place build in J Physician: To the I Examiner: On the band man	e best of my knopasis of examina ner stated.	wiadge death or tion and/or invest	29c. License n	umber	d at the time, dat	d. Date signed (Mo	nth, Day, Year)	

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MEGGET Illiam 5:05 PM 2006 3 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Elizabeth Home Nursing ltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. Month, Day 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** i⊠M 2□F 2 0 312-22-9174 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or Items 23a or 286-f show traumatic event, the Medical Examiner must be notified at mai 1 Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40 MT. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, Ite Made once. Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beury Famil Driver Grade NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MEGGETT MAGGIE ELLIOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MT. Holley St. Baltimore, md. 21229 e Tha - daughter Alston 408 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑Burial 2 □ Cremation 3 □ Removal from State 4-21-06 Park Cemi -oudon 4 ☐ Donation 5/2 Other (Specify) 21. Signature of ral Service Licenses 22. Name and Address of Facility 270 Fred HILTON 23a. Part. They the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.

Immediate Cabse (Final disease or conditions) P. march Freneral Home Dacto, md, 21229 Approximate Interval Between Onset and Death **Physician** Muso borday Whomaton disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner V100 Cu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-transit 40 Monces that initiated events been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Dav 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Corum 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 1 Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16ounic Terles 405 t DMn WD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#10c, 10e-f, 16a, 19b, perFH (854, 4/20/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Mimaroglu 3:30 AM Sait pnl 200 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bultimore Tohns Hopkins 7 he Hospitul 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Months Days Hours Yrs. Director 76 8-24-29 Turkey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 ie marked other then "netural" ---" ery injury or other traumatic even. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA 1 X Yes 2 No Turkey Istaubul Funeral Director Istanbul 10e. Street and Number Saf Sc 10f. Zip Code 10g. Citizen of What Country? 80850 SAF SAFSOK 24 Turkey 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Politician Elementary/Secondary (0-12) College (1-4or 5+) County of Turkey Polition 4 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abdullah Feride Obut Mimaroglu 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sat Sok Enirgan Istanbul 19a. Informant's Name/Relationship (Type, Print) Istaubul, SAF SAFSOK 24 EMIRCAD Wife Turkey Bilge Mimaroglu 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zincirlikuyu Cem. 4-24-06 Istanbul, Turkey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner multiple mylloma nears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): physicien Box 68760 by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: 1 ♣Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 20No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Iniury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai Medical Examiner: United basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29d. Date signed (Month, Day, Year) R. Koem mo RES100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOTA WOLFE ST koe The Bultimore 31. Date filed (Month, Day, Year) 32. pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) APRIL 15 2006 ear **Physician** 12:15 P M MORRIS CORINNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **BALTIMORE** N/A 3031 FALLSTAFF ROAD #601-C 7. Age (In yrs. last birthday) | Hunder 1 Year | Hunder 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 18, 1924 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔽 F NY 099-22-3055 Director Usual Residence of Decedent permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Modical Experiment must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No N/A BALTIMORE Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 3031 FALLSTAFF ROAD #601-C 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 3aitimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION** TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **ADELSON ESTELLE** KLEIN IRVING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 37-8 STONEHENGE CIRCLE - BALTIMORE, MD 21208 JEFFREY MORRIS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BETH MOSES CEMETERY 04/18/2006 PINELAWN, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINS(
8900 REISTERSTOWN ROAD - P)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease of condition resulting in death)

a. BRAHT SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ettending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only only) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours atter death

To the Funeral Director:
completely tilled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 027730 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUALLOS ST. CONEN 6569 32. egistrar's Signature 31. Date filed (Month, Day, Year) State 9 2006

Registrar

			For State	State of Maryland / Dep		Mental Hygie	ne	12256
	20 30		Ragistrar 1. Decadent's Name (First, Middle, Last,		ertificate of Death	Reg.	No.	3. Time of Death
2 9	Physicia /Medic		Kevin W.	Nichols		April 18		5:30 PM
- 2	Examin	er	4a. Facility Name (If not institution, give	street and number) ARITAW HDSPITA	4b. City, Town, or Location of Deat BALTIMOR		4c. County of Death	
* 6	Funeral		5. Social Security Number 6. Sec			8. Date of Birth	9. Birthp	lace (State or Foreign
11.	Director		Usual Residence of Decedent			14-4-		ryiana
	farylan l ehow	ō	10a, State 10b. County	10c. City, Town or L			1	0d. Inside City Limits 1
	or 28e-	Funeral Director	10e, Street and Number		timore 10f. Zip Code	10g.	. Citizen of What Cour	itry?
	eeth wi	eral	5/6/Edged	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (5	Specify Yes or No-	14. Race - Americ	an Indian.
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f ehow eny Injury or other traumatic event, The Medical Examinational Control of the recitied at 2000.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	to Rican, etc.)	Specify: B	
21215-0036	n 72 ho "natur golical	leted	15. Decedent's Edu (Specify only highest grad		edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16t	b. Kind of Business/Inc	dustry
	filed withii Hygiene. Ather than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	security	S	tate of	-MD
Maryland	lid be fill fental Hy rked oth tic even	To Be	17. Father's Name (First, Middle, Last)	one.s	18. Mother's Na	me (First, Middle, Mai	chols	
Mary	12 should h and Men 7 is marke traumatic		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mail	ling Address (Street and Number or R	ural Route Number, C	ity or Town, State, Zip	Code)
	es 1 and of Health filtem 27 r other tr		20a. Method of Disposition	and story are	position (Name of ematory or other place)	Date 200	c. Location - City or To	wn, State
altimore,	permit. Pages Department of Important: If It eny Injury or o		1 Burial 2 Fremation 3 F 4 Donation 5 Other (Specify)	Greening State	ount Grenatory	1/24/06	Baltine	re, MD
Ba	permit. Departr Imports eny Inj		21. Signature of Funeral Service Licens	suio	Vaugh	ietun	eral Se	21217
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. Do not er ne cause on each line.	nter the mode of dying, such as cardia	c or respiratory arrest	- 1 - L	Approximate Interval Between Onset and Death
A Silver	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. HTPATIC 3 Due to (or as a consequence of):	NCEPHALOP	ATIMY		Onsor and Doam
	Examiner		Sequentially list conditions,	. BUD STAGE	CIVER DISE	A5C2		
/	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
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68760,	ficate by physical ph	edical		SARCO DOS	15			
Вох	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date ot delive	ny Day Year
Ö	the deay by the a	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐ Unknown	Other (specify)			
Δ.	res that igned b	Ď	Part II. Other significant conditions con	ntributing to death but not resulting in the	c 11		co use contribute to the	
cord	w requires to been signer should be	leted	(D=(-0-11	d) Pancreat	74	1 ☐ Yes 24a. Was an		ably 4 Unknown psy findings available
Vital Records,	The lav	Completed	Creek r	easy.		autopsy performe	prior to cor	npletion of cause of
Vita	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)		
	g Physier this neral dir	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpatie 28a. Date of Injury (Month, Day Year) 28b. Time (Injury)	HIL SCIDON 4 HOUSING	Home 5 ☐ Residence 28d. Describe how	e 6 Other (Specify injury occurred	()
Division of	Attending or death.	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	294 Longtion (Street	at and Number of Dec	/ C
Div	s after of Birect of Direc	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, sibuilding, etc. (Specify)	treet, tactory, onice	City or Town, S	et and Number or Rura State)	r Houte Number,
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and plac nvestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as si and place, and due to	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	ATTENDING PHYS	29c. License number		Date signed (Month,	Day, Year)
	44				D00600	39.	nct 17 a	7006
	2		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type D SAWIAR 17AY)	/1	BAR	TIMOR	2
	Sta Registi		31. Date filed (Month, Day, Year) APR 1 9 700	3 Registrar's Signature	ale			

DHMH 17 Rev 1/2001

NICABLS

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene		
Certificate of Death	201.6	1995

		1- For State Registrar				Certific	cate of	Death				Reg No. £	201	16	2257
Physicia	_	Decedent's Name	(First, Middle	ddle,Last) 2. Date of Death							ath		3	Time of Death	
ledical Exami		Louis Thoma	as Nemn	hos Jr							Month April 16,	Day 2006	Year	i	2047 hrs
		4a. Facility Name (if					4	b. City, Town, or L	ocation of D				ounty of	Death	
		Harford Rd.	& Manns a	ave.				Parkville				Ва	ltimore	Coun	ty
Funcial		5. Social Security Nu	ımber	6. Sex	7 Age (In yrs. last bi	rthday)	If Under 1 Year	If Under 24	4Hrs 8	3 Date of B	irth (NANA/D)	VVVVV	9 Rirthr	place (State or
Funeral Director								Months Days		10.0			1	Foreign	
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and shov	5	MD	Baltir	nore		Perry	Hall								Yes 2 X No
daryland 28a-f show	Š	10e. Street and Num	nber					10f. Zip Code				10g. Citize	n of Wha	. Countr	y?
he M	Director	7 Haylock	COUR.	t Apt.	201			21236			USA				
vith t	Funeral	11. Marital Status	Cour		ecedent Ev	er in U.S.	13. Was	Decedent of Hisp	anic Origin?	(Speci	fy Yes or N		Race -	America	n Indian, Black,
ath r	le l	1 Never Marrie	d 2 Ma	illeu	Forces?	1		s, specify Cuban,					White,		
ter de	핔	3 Widowed	4 V Divo	1 Ye orced If Yes, Give		No	1	Yes 2 Y No	specify:		Specify: white			+0	
hours afte 'natural'', Examiner	ā	15. Decedent's Edu	74	or Dates:		eted) 16a		's Usual Occupation		of work	k done		d of Busi		
2 hou "nat	ompleted	Elementary/Secon			e (1-4 or 5+)			st of working life. I							,
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215-0036 be filed within 7 nal Hygiene ked other than ent, the Medica	5	12 17. Father's Name (F	First Middle			1 3	ales	118	8.Mother's N	ame (Fi	irst Middle			61.2	
flec flec flec flec	Be C							1.					arriarrio)		1
212 buld be Menta mark c eveu	9	Louis T. 19a. Informant's Nar	Nempno ne/Relationsh	S. Sr.		110	h Mailing	Address (Street	Louis		Byro		or Town	State 7	in Cado)
AD 21215-0036 2 should be filed within 72 h h and Mental Hygiene 27 is marked other than "T	Ė				L 4. L	100		,							ip Code)
e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene item 27 is marked other than "natural", or items 23a or 28a-f she rraumatic event, the Medical Examiner must be notified at once	H	Edward F. 20a. Method of Disp		OS /	<u>broth</u>			iiet Oaks			nk ton ate		2111		wn, State
imore, MD 2121 Pages I and 2 should be finent of Health and Mental I ant: If item 27 is marked or other traumatic eveut,		1 X Burial 2	_	3 Remova	I from State	1	atory or oth		ctory,	U	ate	200. 20	Cation - C	nty of TC	WII, State
more Pages 1 nent of H ant: If i		4 Donation	Other Sp	ecify: _		Dulane	y Vall	ey Mem Gar	dens	4/2	1/06	Ti	moni	um,	MD
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	21. Signature of Fun, 1 Serf. Lice (see) 22. Name and Address of Facility 1050														
ರ ಕೃತ್ತ≣	Ruck Towson Funeral									ral					
Physician		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest												Approximate Interval	
/Medical		failure List only one cause on each ling Immediate Cause (Final disease a Multiple Injuries												- 1	Between Onset and Death
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8760, tificate be en ng physiciar as the burial	§ S	IF FEMALE: 23b. Was decedent p	recent in the		es, outcome	of pregnancy						23d. I	Date of de	elivery	
68 certifi ding	ja i	past 12 months?		I I LIV	e birth		2 Fet	al death 3	Ectopic pre	egnancy	/	M	onth	Day	Year
Box 68' e death certifithe attending the attending the attending the attending the attending the as as as a second the attending	Sic	1 Yes 2 N	o 9 Unki	00000	egnant at tin	ie or death	5 Oth	er (Specify)				4			
that the death cered by the attendidetached for use	Physiciar			a on	known						00 - 0 -1				6.15-950
P.O.	by	Part II. Other signifi	cant conditi	ons contributin	g to death b	ut not resulti	ng in the ur	nderlying cause giv	en in Part I					_	e cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should the		1 Natural		Apr 1	ate of Injury onth Day Year 6, 2006	202	. Time of In 13 hrs			LDa	d. Describe destrian			l	
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ivisiol or Atteno after death Director: I in by the	븰	3 Suicide	6 Could	not be 28e. P	lace of Injur	y - At home,	farm, stree	t, factory, office bu	ilding, etc.	28	f Location or Town		Number	or Rural	Route Number, City
Divipital or ours after our filled in	E	4 Homicide	deten	mined (Speci	fy) Loca	Street				Ha	arford Rd	. / Mann	s Ave.,	Parkv	rille, Md.
Hos 24 hc Fun tely		29a Certifier 1 (Check only	Certifying Ph	ysician: To the	best of my k	nowledge, de	eath occurr	ed at the time, date	e and place,	and du	e to the cau	ise(s) and r	manner a	s started	
Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 🗸	Medical Exan	niner: On the bas	is of examir	nation and/or	investigati	on, in my opinion,	death occurr	red at th	e time, date	e and place	, and due	to the c	eause(s)
2 ≥ 5 8	Βe	29b. Signature and t	itle of certifier		el stateu			29c. License	number			29d. Da	te signed	(Month	, Day, Year)
		1	0 11	71:	/			O.C.M	I.E.			April 1	17, 200	6	
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VI		30. Name and addre		who completed a Assistant Me			111 Dar	n Street, Balt	imoro Mar	D 212	01				
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S Regis	trar APR 1 9 2006 32 Registrar's Signature														
regis	dell	APR 1 9 2006 Signer Ar 19													

Amend item#7, per and Spring The Thepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 9:15 Am Mary Magdeline Pagliaroli April 12. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Fort Washington Rehab Center Prince George's Fort Washington f Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 9, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 🙀 F Atoona, PA 194 09 2160 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "natural", or itama 23a or 28a-f ahow traumatic avant, ita Medical Examinar must be notified at N/A N/A Washington DC 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3117 P. Street S.E. 20020 United States Completed by Funeral be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: White 3 Nidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental (UNKNOWN) Carrie UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16407 Pointer Ridge Drive, Bowie, MD 20716 Elda Sume (Daughter) Health Itam 27 20b. Place of Disposition (Name of cometery, crematory or other place) April 20ate 2006 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur Funeraf Se Ligensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 20735 mo0257 Jours 23a. Párt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherosclerotic **Physician** Cardio Varalar /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed certificete has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 Z No Hospital or Attanding Physician: After this certilice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Z Natural 5 Pending efter death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital c within 24 hours of To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045365 living Ita nd #101 ff washing to un 20748 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) M.D: 11701 Michael Sidanous 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 8 2006

		1 - For State Registrer	State of Ma	aryland / Dep	artment of He	alth and Me		1117 101 101	2259
Physic /Med		1. Decedent's Name (First, Middle Madeline Eliza		ty Perrin			2. Date of Death Month	Pay 2006	3. Time of Death
Exam		4a. Facility Name (If not institution Union Memorial			4b. City, Town, or Lo Baltin			4c. County of Death	1
Funera Director		5. Social Security Number 168-03-4416	6. Sex 7. Aga 1 ☐ M 2 ☐ F	e (In yrs. last birthday 90 Yrs.		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye eb 16, 1	9. Birth 2000 916 Penn	nplace (State or Foreign untry) sylvania
show	or	Usual Residence of Decedent 10a. State 10b. County MD Bal	timore	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 XNo
with the h	Direct	10e. Street and Number 10123 Charing	on Road	, ,	10f. Zip Code 21030		10g.	Citizen of What Co.	untry?
rs after deeth I', or Items 23	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	anic Origin? (Spec Mexican, Puerto R Specify:	city Yes or No- lican, etc.)	14. Race - Amer Black, White Specify:	
Deficiencies, Mary figure 4.1.4.19-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, it a Maridical Expression must be notified at an other traumatic event, it a Maridical Expression must be notified at	Completed b	15. Decedent (Specify only highes Elementary Secondary (0-12)	's Education	(Give	odent's Usual Occupation in the standard of work done during DO NOT use retired)	ing most of workin	g 16t	o. Kind of Business/l	
uld be filed Mental Hygi irked other	To Be Co	17. Father's Name (First, Middle, Frank G.	Conley				(First, Middle, Mail		er
and 2 sho alth and 2 27 ie ma er trauma		19a. Informant's Name/Relations. Edward M. Perri			ing Address <i>(Street</i> and 3 Charingt o				ip Code) 21 0 3 0
Dattillorer Dermit. Pages 1: Department of He mportant: If Iten iny Injury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 4 □ Donation 5 □ Other (S)		20b. Place of Disp cemetery, cra Hilltop	osition (Name of matory or other place) Serv. Corp	4/19/		Location - City or 1	
permit. Departition in moorts any inj		21. Signature of Funeral Service	icens William		2. Name and Address of 1050 York f			Funeral H 21204	ome, Inc.
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each ling	AULTE		-			Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions, if any leading to immediate		a consequence of): BIAD (a consequence of):	er ca	ncer			4 Years
te be executed ysician and le burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome 1 ∐Live birth 4 ∐Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year
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Tospital of thours all funeral bety filled is	edical Ce	(Check only 2 Medical	g Physicien: To the best of Examiner: On the basis of	of my knowledge, dea	th occurred at the time,	date and place, ar	nd due to the cause	e(s) and manner as	stated.
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119		30. Name and address of person		eath (Item 23a) (Type	. Print)	5102 es Stra	A D		2006 Marila 0
Si Regis	tate trar	31. Date filed (Month, Day, Year)	32. Alegistra	-	n CHAVI	es sere	ici Of	ilfimore	MALAND

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Anend Item per doc 8854 4-19-06 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marie Pinkney **Physician** APRIL 20 AM RIE 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner YERLY BAZTIMONE 105P114C NIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, FEB, X 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Hours 214.50-230 1 ☐ M 2 🕱 F Yrs. Director MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Director NIA MARYLAND 10e. Street and Number 10g. Citizen of What Country? 1230 STREET 6 45A Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 3 Widowed 4 ☐ Divorced BLACK "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) Colfege (1-4or 5+) TOMEMAKER 10 HIGRADE OWN traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>Ques</u>. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be PRIGGS THOMAS)A15 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural of ute Number, City or Town, State, Zip Code) STEPHANTE PLANTIE Y-DATLE Y CK-DOT C 4 7 K. R.I.E.L. ST., BALTI HORE

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Localis 140,21201 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF ETERNAL HOPE 04-22-06 SYKESVILLE 22. Name and Address of Faculity 21. Signature of Funeral Service Licensee JR, FUNERAL HOME BROWN FULTON AVE. Approximate fnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician TAR5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. the attending physician Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy page 2 should be detached for Year Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ↓ Unknown peen Ardionyopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 certificate 1□ Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medicat examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1-Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27 Manner of Death 28b. Time of fnjury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide after within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 042634 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLACE BALTIMONE 170 COSTA 301 ST PAUL J 05071-1

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Reginar's Signature

2005

			1 - State of Maryland / Departme Certifica	nt of Health and Mate of Death	1ental Hygier Rog√	CHILL	12261	
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth M. Potthast		2. Date of Death April 15	^{ay} 2006 ^{ear}	3. Time of Death 5:25 p м	
	/Medic Examin			y, Town, or Location of Death Glen Arm		4c. County of Death Baltimo		
	Funeral Director		217-30-3B20 1 M 2ØF 97 Yrs. Month	er 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Yea Nov. B, 1	9. Birth Cou Mar	place (State or Foreign ntry) yland	
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore Glyndon				10d. Inside City Limits 1 □ Yes 2 No	
	with the 1 3a or 28e-	Funeral Director	10e. Street and Number 11 Central Ave., P.O. Box 125	Zip Code 21071		Citizen of What Cou	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hylgiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28e-f show amportent: If item 27 is marked other then "netural", or Items 23a or 28e-f show any injury or other traumatic event. It Medical Evantral must be notified an once.	þ	1 XNever Married 2 Married 1 Yes 2 XNo	eedent of Hispanic Origin? (Sp becify Cuban, Mexican, Puerto 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
Baltimore, Maryland 21215-0036	l within 72 ho liene. r then "netur	Completed	ing 16b.	Kind of Business/Ir				
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imore	Pages 1 and the nent of He sent: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	r other place)		Location - City or T altimore,		
Balt	permit. Departr Importe any inju		21. Signature of Funeral Service Litensee William G. Dau 22. Name 1050	and Address of FacilityRuck York Rd., Tows	k Towson F son, MD 2	uneral Ho 1204	me, Inc.	
ı	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
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8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
P.O. Box 6	that the death certifica ed by the attending ph detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of deliv Month	rery Day Year	
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on of	Attending Physic death. ector: After this by the funeral di	P==	1 Yes 22 No	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in		19)	
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-	Sta Registi		APR 1 9 2006 32. Rigistrar's Signature					

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	Diam'r.		Decedent's Name (First, Middle, Last)	0		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio	al		YKO . 118		APRIL	6 06	
·	Examir	. ½		NTER	4b. City, Town, or Location of BALTIMOR! If Under 1 Year If Under 2	E, MD	4c. County of Deal	2
*	Funeral Director		5. Social Security Number 6. Sex 214-24-9797 1 M 227F Usual Residence of Decedent	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	Months Days Hours	Min. 8. Date of Birth (Month, Day)	Year) 1979	thplace (State or Foreign funtry)
	Aaryland	ō	10a. State 10b. County	10c. City, Town or Lo	ncation ABR F		-	10d. Inside City Limits 1 √Yes 2 □ No
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21215-0036	be filed within 72 hours after death with the Marylan ital Hygliene. Id other then "naturel", or items 23a or 28e-f show of other then "naturel", or items 23a or 28e-f show event, the Madical Examiner must be notitied at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	(Give	dent's Usual Occupation kind of work done during most DO NDT use retired)		6b. Kind of Business.	Industry
	ld be fited ental Hygi ked other fc event, I	Be	17. Father's Name (First, Middle, Last)			's Name (First, Middle, M	laiden Sumame)	
Maryland	and M and M is mar	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number	or Rural Route Number,	City or Town, State,	Zip Code)
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Place of Dispo	osition (Name of matory or other place)	Date 2	Oc. Location - City or	Town, State
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	, }		30. Name and address of person who completed cau	KIA MD ME	ERCY MEDIO	AL CENTE	R BALT	IM ORE MA
	Sta Regist	ate rar		Registrar's Signature	Print)		,	

	1	For State Registrar	State of	Marylan			t of Health a e of Death	and Me		ene	5	1226	3
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with the Mass or 28a-f	,	0e. Street and Number 120 Twin Circle - South				10f. Zip	Code 2123	0	10	g. Citizen of	What Co		
Ind 21215-0036 half within 72 hours after death with the Maryland half lygiene. do other than "natural", or items 23s or 28s-1 show event, the Madrel Exeminar must be notified at Recommisted by Eumeral Director.		1. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🖄 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? X No	1	Vas Deced f Yes, spec 1 ☐ Yes	dent of Hispanic Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original Control Original	gin? (Spec , Puerto R	cify Yes or No- lican, etc.)		ck, White	rican Indian, n, etc. 3lack	····-
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should be filed within and Mental Hygiene. In Mental Hygiene. In Mental Hygiene.	3 1	7. Father's Name (First, Middle, Last Mark	Harvey				18. Mothe	r's Name	(First, Middle, Mi Eula N	aiden Sumai M. Harve			
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Baltimore, Dearmit. Pages 1 at Department of Hea Important: If item and injury or othe	2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1 ^	Place of Dispo emetery, cren Mt.	natory or o	me of other place) emetery	04	4/15/06	Dc. Location Lanso		Fown, State Maryland	
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Vital Figure 1 The sicien: The scentificate linector, page 100 Per Co.)	25. Was case referred to medical examiner?						of Death	Check only one				
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To th within To th compl	JIA	29b. Signature and title of ceruitier	630	\	10	290	C. License number	116	29.	d. Date signe	ed (Month	Day, Year)	
3		30. Name and address of person who	completed cause	o death (Item	n 23a) (Type,	Print)	-000	And	JAPO	Cis	,	Rd	
State Registra		31. Date filed (Month, Day, Year) APR 1 9	The same of the sa	isfrar's Signa	ature	ach!)						

			1- State of Maryland / Dep State of Maryland / Ce	artment of Health and Natificate of Death	, ,	ene g. No. 006	12264
	*	<	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Aldena L. Pinkney		April '	11,2006	9:14AM M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
- 35			Southern Maryland Hospital	Clinton If Under 1 Year If Under 24 Hrs.		Prince G	
1 20-	Funeral Director		5. Social Security Number 217-30-0598 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday, 74 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Nov. 26	Year) 9. Birth Co.	place (State or Foreign intry) shingten
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	dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	
15-0036	d within 72 hours after death with the Marylar plane. Than "natural", or Itame 23a or 28a-f ehow The Medical Examinat must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:	,	Specify: Bla	_
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ב כ	within 72 ene. than "nai he Medic	npie	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	any		
N	ygien ygien yerth t, the	Co	12	Aide		Edgemeade	Center
Maryland	be fill d ott	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M		
Š	should nd Men marke umatic	ဍ	Theadore Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rur	an Betts		in Codo)
<u>8</u>	12 ha			9 Van Brady Rd.		, , , , ,	, - ,
<u>6</u>	f Healt f Healt item 2 other		20a. Method of Disposition 20b. Place of Disp	osition (Name of		0c. Location - City or 1	
aitimore,	Page nent o ant: If ury or			United Meth. 4/	18/06	Upper Mar	rlboro, Md
Rail	permit Depurt Import any nj			2. Name and Address of Facility Ac		neral Hom sco. MD 2	•
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. (List only one cause on each line.				Approximate Interval Between
١,	hysician		Immediate Cause (Final disease or condition	ray Emboli	-14-		Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	/			I Fred V
*	Examiner		Sequentially list conditions b. melasta	tec lung Co	in cen		Willmow
	v #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	/			
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	57Rudinel	02111	Sease	mknow
8760,	be e) ician buria		but to (or as a consequence or).				
289	icate phys s the	dical	d				
XOR	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	/erv
ň	death e atte	iciai	in the past 12 months 1 Live birth 2 Fetal death 31 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
		hys	9 ☐ Unknown				
ω̂ Σ	requires that the been signed by th hould be detachs	by P	Part II. Other significant conditions contributing to death but not resulting in the o	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ğ	w require been sig should b	ed			1 ☐ Ye	s 2 No 3 Pro	bably 4 Llaknown
ပ္မ	s t	Completed			24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of
<u></u>		e Co	25. Was case referred to predical		1□ Yes 2	☐No 1☐Yes	2 No
5	Physician: r this certific ral director,	0	examiner? 1 Yes 2 10 Hospital: 1 Inpatient 2 ER/Outpatie	Othor	th Check only one	nce 6 □Other (Spec	4.3
	y Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	THE SELDON 4 INDISING THE	28d. Describe how		(ry)
<u></u>	nding I tth. r: After e funer	aţio	1 □ Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division	or Attending ifter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
בֿ	spital or lours afte neral Dir filled in						
	5 4 T S	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	
	0		11/1/16	50459	A.	121/12/	06
	5		30. Name and address of person the completed cause of death (Item 23a) (Type	21		·	
	Sta Registr	_	31. Date filed (Month, Day Year) 32. Relistrar's Signature		1		
			- LOUD BOMBER TO				

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ORIGINAL

			For Stata Registrar	State of M	-	epartmen Certificate			d Mental Hy	giene	6 12265
	Physici /Medio Examin	al	Decedent's Name (First, Middle Color of the Color of	T	'enkal		Town, or Lo	ocation of D	2. Date of De Month April		
	Funeral Director		Johns Hopkin. 5. Social Security Number 192-24-5084		ge (In yrs. last birt	0 1		f Under 24 l	Hrs. 8. Date of Bir (Month, Da Feb 14	th ly, Year) , 1932 I	9. Birthplace (State or Foreign Country) Pennsylvania
	he Maryland 28a-f show otified at	ector	Usual Residence of Decedent 10a. State 10b. County MD Anne 10e. Street and Number	Arundel	10c. City, Town	or Location yn Park	Codo			10g. Citizen of Wh	10d. Inside City Limits 1 □ Yes 2 🛣 No
936	4 within 72 hours after death with the Maryland jiene. r than "natural", or liems 23a or 28a-1 show the Medical Examinar rout Le notified at	by Funeral Director	286 Stanley Te 11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced	12. Was Decedent Amed Forces' ried 1 XYes 2	? No	21.13. Was Deced	225 lent of Hispa ify Cuban, I	anic Origin? Mexican, Po Specify:	(Specify Yes or No Jerto Rican, etc.)	U.S.A. 14. Race Black, Specify:	- American Indian, White, etc. White
121215-0036	d within glene. r than "	Completed		nt's Education sit grade completed) College (1-4or	16a. 5+)	Decedent's Usua (Give kind of wor life. DO NOT us oldier	rk doné duri se retired)	ing most of	working Name (First, Middle,	16b. Kind of Busi United Army	iness/Industry States
Maryland	Anthony Penkala Pauline Margarvitch 19a. Informant's Name/Relationship (Type, Print) Pauline Margarvitch 19b. Mailing Address (Street and Number or Rural Route Number, City or Tope of the state of										tate, Zip Code)
Baltimore, I	Page nent o ant: If ury or		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 1 ☐ Donation 5 ☐ Other (S	3 □Removal from State	20b. Place of cemeter	Disposition (Namy, crematory or of one of the creation)	ne of ther place) emator	ry Ag	Date or 21, 06	20c. Location - Co	
			21. Signature of Funeral Service 23a. Part 1. Enter the disease, or shock, or heart tarture. List Immediate Cause Final	r complications that cause	M00773 d the death. Dor] 313 Ta	albott	t Ave.		Maryland	20707-4389 Approximate Interval Between Onset and Death
68760, 🗷	death certificate be executed e attending physician and e attending by sician and add for use as the burial-transit or of the purial transit or o	ilcal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ventila	ter Assistance of a consequence of	ilure sciated	Phen. Imono	monia	Disease		Minutes Months Months Years
.O. Box	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death t time of death	3 □Ectopic pro				23d. Date Month	
Records, P	e law requires has been sign je 2 should be	Completed by PI	Part II. Other significant conditions Gastrointestin Congestive hea	al hemorri	but not resulting in	Anemi	_	in Part I.	1 ☐ 1	Yes 2 □ No 3	pute to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of ath?
of Vital	Physician: r this certifica ral director, I	To Be	INSINTTICIENCE 25. Was case referred to medical examiner? 1 □ Yes 2 No 27. Manner of Death	Hospital: 1 Inpati		tpatient 3□DC	Other	4 🗌 Nursin	1 ☐ Yes Death (Check only of g Home 5 ☐ Resident of the second of the	2 No 1 Cone)	☐ Yes 2 ☐ No (Specify)
Division	at at a	Certification:	1 XNatural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home, fa tc. (Specify)	М	1 🗌 Yes	s 2□No	28f. Location (City or Tou		r or Rural Route Number,
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	Medical (ng Physician: To the best Examinar: On the basis of and manner s	of examination and	d/or investigation,		ion, death o			nd due to the cause(s)
)	(KY)		30 Name and address of person	who completed cause of miles 5505	death (Item 23a) (Tuno Print)	043		Baltimo	April 17	, 2006
	Sta Regist		31. Date filod (Month, Day, Year,	171	rar's Signature	books			J 111/10	· av	finna

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma			of Health and of Death		ene 0 0 6	12266
I	Physici		1. Decedent's Name (First, Middle, Las	an f	7.1/1	KOF	_	2. Date of Death Month	Day Year	3. Time of Death 9:00 p M
>	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Location of Dea		4c. County of Death	
			412 Valley Meadow				isterstown 1 Year If Under 24 Hrs		Baltim	
	Funeral Director		ELO JE-EJJO		(In yrs. last birt	Months Months	Days Hours Min		941 VEW	place (State or Foreign nin) ginia
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	mary Mary	tor	Maryland Baltimo	ore	Rei	stersto	vn			1 ☐ Yes 2 ☐ No
	or 28	Funeral Directo	10e. Street and Number	~		10f. Zip		10g	. Citizen of What Cou	•
	eath v	erai	412 Valley Meadow	12. Was Decedent E			1136	Specify Vec or No	U.S.A	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of health and Mental Hygiene. Depertment of health and Mental Hygiene. Important: if Item 27 ie marked other then "natural', or Iteme 23a or 28a-f ehow amy injury or other treumatic event, the Medical Examinar must be notified at once.	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		If Yes, spec	ent of Hispanic Origin? (: ify Cuban, Mexican, Pue : XNo Specify:	rto Rican, etc.)	Black, White,	
5 0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's Usua (Give kind of work	Occupation k done during most of wo e retired)	orking 16	b. Kind of Business/In	dustry
7	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	Pro	perty Ma			David O. F	eldmann
0	filed Hygie other	ပိ	17. Father's Name (First, Middle, Last)			por og tre		me (First, Middle, Ma		Jul Cameria
an	fental fental rked c	To Be	Richard Brown				Halli	le Gross		
ary	and N	_	19a. Informant's Name/Relationship (7	Гурө, Print)			(Street and Number or F			
Σ «`	and 2 ealth m 27 i		Ellie Cook - daugh	nter			Meadow Cir			
altimore,	Pages 1 lent of H nt: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	Disposition (Namy, crematory or ot Crematory	her place)		c.Location-City or To Baltimore,	
Balti	permit. Depertm Importa any inju		21. Signature of Funeral Service Licen			Eckharo	Address of Facility (Resiterstown	Chapel P.A.	, Wille N	VA 24117
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	olications that caused t	he death. Do n	at enter the made	of dving such as cardia	ic or respiratory arrest		Approximate
	Physician /Medical Examiner		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	consequence of	(- CM !!	chsp	A 15000	115	Interval Between Onset and Death
	, y	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence c	ń).				
	ficate be executed physician and is the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a	consequence o	of):				
68760,	e be e /siciar e buria	edicai E	0	d						
		Medi	IF FEMALE:							
P.O. Box	the death certiff the attending ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	☐ Fetal death	3 □Ectopic pre 5 □ Other (spe			23d. Date of delive Month	ery Day Year
	The law requires that the de tte has been signed by the a page 2 should be detached t	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying ca	use given in Part I.	23e. Did toba	co use contribute to the	ne cause of death?
rds	w require: been sig should bo							1 🖫 es	2 □ No 3 □ Prob	pably 4 Unknown
Vital Records,	lawre as bee	Completed	1					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
		Con						performe	d? death?	2 13 10
Vita	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			O+	ath (Check only he)		
ō	Phys r this ral dii	- To	1 Tes 2 No 27. Manner of Death	1 ☐ Inpatien		patient 3 DO		Home 5 Hesideno 28d. Describe how	e 6 Other (Specification)	y)
on	nding Ph th. :: After th e funeral	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		jury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	254. 25501150 11511	inquity obscurred	
Division of	To the Hospital or Attendi within 24 hours effer death. To the Funerel Director: A crimpletely filled in by the fo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, far (Specify)	m, street, factory,	office	28f. Location (Stree City or Town, S	et and Number or Rura State)	d Route Number,
	To the Hospital or within 24 hours efte To the Funeral Dir completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge,	death occurred a	it the time, date and plac	e, and due to the caus	se(s) and manner as s	tated.
	the Ho in 24 the Fu pletel	edical					in my opinion, death occ			
)	or with	Σ	29b. Signature and title of certifier Success 30. Name and address of person who of the success of person who of the success of person who of the success of person who of the success of person who of the success of person who of the success of person who of the success of t	Cema	is in	D. 7	License number	29d	Date signed (Month,	Day, Year)
į	0 1		30. Name and address of person who de August of Ste	completed cause of dea	ath (Item 23a) (Type, Print)	unt head	PIKOSE	ilk lung	ylou
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	's Signature	1		-		
	Registr	ar	APR 1 9 20	06	S. A.	GOODE!				
DHM	MH 17 Rev 1/2	001		10						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore .Center D If Under 1 Year If Under 24 Hrs. 8. Date of Birth
House Min. (Month, Day, Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-92-2853 27 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at MD Prince George's Oxon Hill 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6906 Elkins Avenue 20745 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry East Coast Elementary/Secondary (0-12) College (1-4or 5+) 12 Delivery Driver Building Supply Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Menta Important: If item 27 le marked Jerry M. Quick, Sr. Violet Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Quick - Wife 6906 Elkins Avenue, Oxon Hill, MD 20745 20b. Place of Disposition (Name of comptent, crematory or other place)
Glen Haven
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State ö 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd.. Langdown Donation 5 Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Live eny in 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Examiner Sequentially list conditions Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine genous Leukenlia To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? (es 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 1 ■ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

17

DHMH 17 Rev 1/2001

of death (Item 23a) (Type, Print)

South Greene

P 18568

Street Baltimore, MD

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Registrar	Death	Re	eg. No.	10000
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)		2. Date of Dea Month April 15, 2	Day Year	3. Time of Death 2108 hrs
		THE TENED IS NOT THE TENED IN T	City, Town, or Location of Dea Baltimore City		4c. County of Death	I/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-35-3813 1 M 2 F 14 Yrs.			th(MM/DD/YYYY) 9 Birt	hplace (State or
21215-0036 Uld be filed within 72 hours after death with the Maryland handl Hyghers marked other than "natural", or items 23a or 28a-f show any event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	Usual Residence of Decedent 10a. State	MORE CITY 10f. Zip Code 21 21 5 Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer Yes 2 X No specify: s Usual Occupation (Give kind of st of working life. DO NOT use of DENT 18.Mother's Nar	Specify Yes or No to Rican, etc.) of work done etired)	Og. Citizen of What Cour US A 14. Race - Americ White, etc Specify: BLA 16b. Kind of Business/In STUDENT Maiden Surname)	10d Inside City Limits 1 X Yes 2 No No No CK CK ndustry
Baltimore, MD 2121 Example 21 and 2 should be fine a population of Health and Mental important: If liter 27 is market a population of the	er To	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service (Ice see 22. Na	r place) CEMETERY 4 me and Address of Facility H OO LIBERTY H mode of dying, such as cardiac	, APT. Date /21/06 OWELL FEIGHTS	B, BALTIM 20c. Location - City or LANSDOWN UNERAL HOL AVE - BALT	ORE, MD Town State E, MD ME 21207
P.O. Box 68760, sthat the death certificate be executed greed by the attending physician and edeached for use as the burial - transit	Medical Examin	C. Due to (or as a consequence of): UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions C. Due to (or as a consequence of): AMENDED item#28a-b,perME, 98 23c. If yes, outcome of pregnancy 1 Live birth 2 Feta 4 Pregnant at time of death 5 Others.	I death 3 Ectopic preg		23d. Date of delivery Month D	ay Year
Division of Vital Records, P.O. Box 68760, To the Hnspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Certification: To Be Completed by	25. Was case referred to medical examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a Certifier 25. Was case referred to medical Hospital: 1 Inpatient 2 Per ER/Outpatient 2 Per ER/Outpatient 2 Per Pown 5: 1 Inpat	ury 28c. Injury at Work? 1 Yes 2 No factory, office building, etc.	24a. Was autop performance of the second of	sy med? 2 No 1 Ve Residence 6 Other now injury occurred t Street and Number or Rurtate) Roslyn Avenue, Ba e(s) and manner as starte	opsy findings available ompletion of cause of s 2 No No No No No No No No No No No No No
3 Regis	tate trar	31. Date filed (Month, Day, Year) 32 Egistrar's Signature	treet, Baltimore, MD 212	201		
Drivin 17 Rev 172	TOU	ORIGINAL				

			1 - For State Registrar			or iviaryia		epartme Certifica		eaith and N Death		Reg. No.	005	12269
	Physici	an	1. Decedent's Name Florence		-						2. Date of Do	eath 13, ^{Day} 20	006 Year	3. Time of Death 6:45 A. M
	/Medio Examir		4a. Facility Name (If The Wesle	_	re street and nu	mber)			ity, Town, or 1 1timo	Location of Death			ounty of Death	
	Funeral Director		5. Social Security Nu 216-03-314		Sex I□M 252[F	7. Age (In ye	rs. last birth Yı	Month	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di March	rth ay, Year) 24, 19	9. Birth Cou Pen	place (State or Foreign ntry) nsylvania
	aryland •how		Usual Residence of I	Decedent 10b. County	!	10c.	City, Town	or Location						10d. Inside City Limits
	r 28a-f ehow	ector	Maryland							Baltimo	ore			11⊠Yes 2 No
AM	death with the Maryland ms 23s or 28s-f show ricust be notified at	i Dire	10e. Street and Num 2211 W. F		ve.				Zip Code 21209			_	en of What Cou d State	•
Horence 66:45 AM	after or its	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 ☒ Widowed 4	-	12. Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	2 ፭ ₹No ve	U.S.		cedent of Hi specify Cuba s 2 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ectly Yes or No Rican, etc.)	1	Black, White Bpecify: Wh:	etc.
15-0	n 72 ha "natu solical	ietec	(Specif	15. Decedent's E fy only highest gr	ducation ade completed)		16a. C	ecedent's U Give kind of	Isual Occupa work done o	ition luring most of work)	ring	16b. Kind	of Business/Ir	ndustry
2002	filed withi Hygiene. other then	Somp	Elementary/Secon	dary (0-12)	College (1-4or 5+)		ental				Heal	Lth Car	e
and Sepa	ges 1 and 2 should be filed within 72 hours it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or other traumatic event, the Medical Exa	To Be Completed by	17. Father's Name (F Ewalt B.							18. Mother's Nam Margie I	,	e, Maiden Si	umame)	
व रेड	2 shoul and Me le mark aumatk	Ĕ	19a. Informant's Nar	, ,				_		nd Number or Rur	al Route Numb			
- Moi	s 1 and 2 of Health item 27 other tra		Louis J.		, Sr /			002 Fr			Secretary and the second		MD 212 ation - City or T	
Rotan Expire	Pages nent of ant: If it ary or c		1 🗆 Burial 2 🛭	Cremation 3 ☐ 5 ☐ Other (Special				Cremat	ory	2006		Cator	nsville	, Maryland
Ro Balt	permit. Page Department o Importent: If eny injury or once.		21. Signal 18 - Fun	eral Service Lice	nsee	M01290	n	22. Name Funer	and Addres	s of Facility Ste ne of Cat lson Ave.	rling-lonsvil	Ashtor le, Ir	n-Schwa	b-Witzke
			23a. Part 1. Enter the shock, or near	e disease, or com	plications that			t enter the m	Eamone node of dying	ason Ave.	or respiratory a	nsv111 arrest,	Le, MD	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (F disease or condition resulting in death)	inal		6.								Onset and Death
	/Medical Examiner				Due to	(or as a cons	equence of	ii Eeri Va	es cul	n. En Disc	ine			
V	pe sit	iner	Sequentially list con- if any, leading to im- cause. Enter Under! Cause (Disease or in that initiated events	ditions, nediate lying	Due to	(or as a cons	equence of):						
o'	execut an and rial-trar	Exan	that initiated events resulting in death) La	ast	c. Due to	(or as a cons	equence of):						
68760,	tificate be executed ig physician and as the burial-transit	edicai Examiner	d											
P.O. Box 6	The law requires that the death certifi tte has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ Unknown	nonths?		oirth 2 ⊡Fe nantattimeo	etel death	3□Ectopio 5□ Other	c pregnancy (specify)			23	d. Date of deliv Month	ery Day Year
S.	es that gned b	by Pr	Part II. Other signific	cant conditions	contributing to d	eath but not r	esulting in t	he underlyin	g cause give	n in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ord	w requires that been signed to should be det	eted	Ostocyan	usis, 1	enal 5	insuf	hey							pably 4 Munknown
Division of Vital Records,	The law te has age 2 s	Completed by					0				24a. Was auto perfe		prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
/ital	Physicien: The la this certificate har ral director, page 2	Be	25. Was case referre examiner?		Hospitale	-			04	26. Place of Deat	h (Check only	one)		
of	S 0	n: To	1 ☐ Yes 2 📉	40		Inpatient 2 of Injury th, Day Year)	ER/Outp	ne of	DOA Other	4 Nursing Ho	ome 5 Res 28d. Describe			(y)
sion	tending leath. tor: Aft the fun	catio	1 Accident 2 □ Accident 3 □ Suicide	5 ☐ Pending investigatio	n			М	101	? ′es 2 □ No				
Divi	al or At s after o	Certification:	4 Homicide	determined	289. Place	of Injury - At ing, etc. <i>(Spe</i>	t home, tarn cify)	n, street, fact	tory, office		28f. Location (City or To	(Street and I wn, State)	Number or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Crieck only one)	1⊠'Certifying Pl ∠∐ Medicai Exai	niner: On the b	best of my k asis of exami ner stated.	nowledge, o	death occurr or investigati	ed at the tim ion, in my op	e, date and place, inion, death occur	and due to the red at the time,	cause(s) ar , date and p	nd manner as s lace, and due t	stated. o the cause(s)
	To the To the complete	Me	29b. Signature and t	itle of certifier	0				29c. License	number		29d. Date :	signed (Month,	Day, Year)
	.1		20 Nome and addition	. Jelu	Jun	t of darth "	lam aar \ ce	una Brier	y	3146x			4/13/0	\$
	4		30. Name and addre	BANZ S	T B	2 Ltu	19m 23a) (1	ype, Print)	122	e Ro	BERT	LIBer	to.n	(D)
	Sta Registr		31. Date filed (Month	APR 1 9	2006 32.	légistrar's Sig	gnature	Spark					7	

			For State Registrar	State of	Maryland		artment rtificate			and Me		iene	6	12270	
	Physici	an	1. Decedent's Name (First, Middle, Last								Date of Dea Month	Day	Year 20 6	3. Time of Death	м
ı	/Medic Examin		Edwin A. Ri 4a. Facility Name (If not institution, give		er)		4b. City, To	own, or	Location o		4000	4c. County			_
	Funeral	*	Keswick Multi-Car 5. Social Security Number 6. Se		Age (In yrs. la	st birthday) Yrs.	If Under 1		If Under a	24 Hrs. 8 Min.	Date of Birth	Year)	Cou	place (State or Foreigntry)	gn
	Director		580-64-8116 Usual Residence of Decedent		76					A)	pril 22	,1929		to Rico	
	Marylar f ahow	tor	10a. State 10b. County			Town or Lo								10d. Inside City Limit: 1 X Yes 2	
	or 28e	Directo	Maryland 10e. Street and Number		Dal	LLTIIOL	10f. Zip C	ode			1	0g. Citizen of	What Cou	ntry?	
	ns 23e	Funeral I	217 Chancery Road	12. Was Decede	nt Ever in U.S	. 13.	2121 Was Deceder		spanic Orio	gin? (Speci	fv Yes or No-	USA 14. Rad	ce - Ameri	can Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilh and Mental Hygiene. Important: if item 27 is marked other than "netural", or Items 23e or 28e-f ahow any injury or other traumatic avant, the Medical Exactinating the notified at once.	y Fun	1 ☐ Never Married 2 🔀 Married	Armed Force 1 X Yes 2 (If Yes, Give	□No		If Yes, specify 1 2X Yes 2				fy Yes or No- can, etc.)	l l	ck, White		
Maryland 21215-0036	2 hours etural	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu		s:		dent's Usual (ation		o Rico	16b. Kind of B	WI	ite	
1215	within 7 ine. ihan "n	Completed	(Specify only highest grad	College (1-4	or 5+)	life.	kind of work DO NOT use	retired)	u <i>ring m</i> osi)	t of working					
ر ام	illed v Il Hygie other I	Be Co	17. Father's Name (First, Middle, Last)	5+		Phys	sician		18. Mothe	or's Name (i	First, Middle,	<u>Medici</u> Maiden Sumar			
ylar	iould be I Menta narked natic av	ToE	Ricardo Rivera						4.5	eda F					
Ma	nd 2 sh alth and 27 ia n r traum		19a. Informant's Name/Relationship (T) Delma Rivera	Wife			•					; City or Town Maryla		· ·	
altimore,	ges 1 a t of Hea ffitam or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	Removal from Sta	20b. Pla	ace of Dispo metery, crei	osition (Name matory or othe	of er place	9)	Dat	te	20c. Location	- City or T	own, State	
<u>=</u>	artmen ortant: injury e.		4 □ Donation 5 □ Other (Specify)21. Signa proof Funeral Service Lice		Pro	spect	Hill 2. Name and	Cem	s of Facilit	/21/2 vSter	2006 <u>Y</u> ling As	ork, Pe	ennsy chwal	lvania Witzke	
ñ	Dep Imp any		Clara	tole	#	j	Tuneral 630 Ec	l Ho lmor	me o: ndson	f Cato AVen	onsvill ue; Cat	le,Inc consvil	1e, 1	Witzke MD 21228	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on eacl	sed the death. h line.		ter the mode o	of dying	g, such as	cardiac or r	respiratory arr	est,		Approximate Interval Between Onset and Death Hillurs	,
	/Medical Examiner		resulting in death)	Due to (or	as a conseque		ic hy	A als	dr.p.	Ohic				Years.	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):	co rog	100	,, -0,	- ray					
8760, <	ate be executed hysician and the burial-transit	I Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or	as a conseque	ence of):									
687	ate hy the	edlcal	•	d											
S. Box	The law requires that the death certific ite has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ∏ Fetal of t at time of dea	death 3[⊒Ectopic preg ⊒ Other (spec						ite of deliv	ery Day Year	
P.0	that the de ned by the a detached to		Part II. Other significant conditions co	ntributing to deat	h but not resul	ting in the u	inderlying cau	ıse give	n in Part I.		23e. Did to	Dacco use con	tribute to 1	he cause of death?	
ords	w requires that been signed t should be det	ted b	Tulli-infarct	den	ente						1 🗆 Yı	s 2 12 No	3 ☐ Pro	bably 4 □Unknow	n
Vital Records,	The law rate has be page 2 sh	Completed by									24a. Was a autops perform	ned?	Were autoprior to codeath?	opsy findings available impletion of cause of 2 No	9
Vita	Physician: The k this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital: 1 □ Inp	ationt 2 TF	R/Outpatier	nt 3 DOA	Othe	r /		Check only on	ence 6 🗆 Oth	oer /Sneci	64)	
Division of	nding Phy th. : After this s funeral d	tion; To	27. Manne Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of I		28b. Time o Injury		c. Injury Work	at	28		ow injury occur		(9)	
Divis	al or Attending Is after death. Il Diractor: After din by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of building,	Injury - At hon , etc. (Specify)	ne, farm, sti	reet, factory, o	office		28	f. Location (Si City or Town		ber or Rur	al Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certified completely filled in by the funeral director,	edical	29a. Certifier (Check only one)		s of examination										
,	To the within 2 To tha complet	ğ	29b. Signature and title of certifier	a Onn	مل الدين	7)			number 5 7			9d. Date signe		*	
	10		30. Name and address of person who c	ompleted cause of REGRE	of death (Item :	23a) (Type,				BAIT	(TDDF	Spril 1	1511	ov Q	
	Sta	ite	31. Date filed (Month, Day, Year)	32. F/g	of death (Item :	TO A	Jack!	(00	- ' / '		, ., .,	, ., 9 30	10011		
	Registr	ar	APR 1 9 2	006	Corner d	19									

			1 - For State Registrar	State of Maryland	Department of He Certificate of D	ealth and Mental Hy Leath	giene 0 0 6 227 Reg. No.
	Physici	an	Decedent's Name (First, Middle, Las	" " "	7000	2. Date of De	
	/Medic	al	4a. Facility Name (If not institution, give	ACE RU	12 6 4b. City, Town, or L.	Ocation of Death	4c. County of Death
-	Examin Funeral Director	ier	Wood LAPDS 5. Social Security Number 6. Se	ASSISTANT	MIDD birthday) If Under 1 Year	LE RIVER If Under 24 Hrs. 8, Date of Bin Hours Min. 4 Hours American	BALTIMORE CO
	ס		Usual Residence of Decedent 10a. State 10b. County	/ 10c City T	own or Location	1000	10d. fnside City Limits
	Maryli e-f eho	to	MD. N	A BA	LTI MORE	•	1 Nes 2 □ No
	or 28s	Direc	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	ne 23a	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hist	224 panic Origin? (Specify Yes or No	14. Race - American Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelith and Mentalle Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show important: if item 27 is marked other then "natural", or items 20a or 28a-f show eny injury or other traumatic event. The Medical Examinar must be notified at once.		1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 _ Yes 2 No If Yes, Give Year or Dates:	_ V	panic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	Black, White, etc. Specify: WHITE
15-0	in 72 h n "natu ledicel	ojeted	15. Decedent's Ed (Specify only highest grad	de completed)	6a. Decedent's Usual Occupati (Give kind of work done dur life. DO NOT use retired)	on ring most of working	16b. Kind of Business/fndustry
212	filed withi Hygiene. other ther	Completed by	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	INTERNAT	TONAL PAPER	LINES
and	d be fited intal Hygi od other	Be	17. Father's Name (First, Middle, Last)	E. Mann!	() (ha)	8. Mother's Name (First, Middle,	Maiden Sumame)
Maryland	2 should the and Ment is marked aumatic	٦ ک	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Street and	AROLINE d Number or Rural Route Numbe	er, City or Town, State, Zip Code) 2/206
	1 and 2 Heelth a tom 27 io		LOBRAINE ROS	EN BERGER	4002 CHE	SLEY AVE	BALTO, MD.
TOL	Pages 1 nent of H int: if its iry or ot		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	e of Disposition (Name of etery, crematory or other place)	APRIL 11	20c. Location - City or Twn, State
Baltimore,	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Services Licens		22. Name and Address	of Facility 2829	HUDSON ST. 21224
			23a. Part1. Enter the disease or comp shock, or heart failure. List only	lications that caused the death. If	Do not enter the mode of dying,	such as cardiac or respiratory ar	Interval Between
7	Physician /Medical		fmmediate Cause (Finaf disease or condition resulting in death)	Bright C	ANUTR		Onset and Death
	Examiner		6	Due to (or as a consequent	ice of):	TIVE (ULAN	owen, Disease
LY	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ice of):		Joy Joy Con
1	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	c	ce of):		
68760,	icate be executed physicien and s the burial-transit	edicai	(d			
		/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			22d Date of delivery
P.O. Box	w requires that the death certif been signed by the attending should be detached for use a:	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 5 No 9 ☐ Unknown	1 Live birth 2 Fetal de: 4 Pregnant at time of death 9 Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ords, F	equires tha en signed l ould be det	þ	Part fl. Other significent conditions co	ntnbuting to death but not resultin	ng in the underlying cause given	in Part I. 23e. Did to	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
Division of Vital Records,	or Attending Physician: The law requires that the death certil tiler death tiler death tiler death carding Directors. After this certilicate has been signed by the attending in by the funeral director, page 2 should be detached for use a	Completed					
Vits Vits	sician s certifi irector	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/	Othor	26. Place of Death Check only o	
n of	ng Phy fter this neral c		27. Manner of Death 1 Naturaf 5 Pending		b. Time of Injury a Work?	4 Nuising Home 3 Hesit	now infury occurred
Sio	ttendil death. stor: A the fu	icati	2 Accident investigation 3 Suicide 6 Could not be		M 1 ☐ Ye	es 2 🗆 No	Street and Number or Rural Route Number,
<u>.≥</u>	tal or A s after el Direc ed in by	Certification:	4 Homicide determined	building, etc. (Specify)	, larm, street, ractory, office	City or Ton	vn, State)
	To the Hospital or Attending Physician: The law within 24 hours after death, within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Medical	one) 2 Medical Exam	iner: To the best of my knowles iner: On the basis of examination and manner stated.	dge death accurred at the time, and/or investigation, in my opin	nion, death occurred at the time,	date and place, and due to the cause(s)
	To t	Σ	29b. Signature and title of certifier	dhi	29c. License n	number 7 7 7	29d. Date signed (Month, Day, Year)
		10	30. Name and address of p son who d	ompfeted cause of death_fitem 23	(Type/Print)	0))	711010
	V		I. Shavia	2615.10	tilland f	m pms.	M1) 21224
*	Sta Registr		31. Date fifed (Month, Day, Year) APR 1 9 7	32. Registrar's Signature	a forte	V	

		State of Mai		artment of Hea		ental Hygie	211116	12272
Physici /Medi		1. Decedent's Name (First, Middle, Last) Robert Eugene Rose	nthal			2. Date of Death Month	Day Year	3. Time of Death 7.′00 Å M
Examir Funeral	ner		(In yrs. last birthday,		Park	8. Date of Birth (Month, Day, Ye	9. Birth	pplace (State or Foreign
Director		029-22-6755	74 Yrs.			10-7-193		sackusetts 10d. Inside City Limits
ith the Mary or 28a-f ah	Director	10e. Street and Number	Rockvil	10f. Zip Code		10g.	Citizen of What Cou	1 ☐ Yes 2 No untry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Exampliar must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evarmed Forces? 1 Yes, Give Year or Dates:			Specify:		14. Race - Amer Black, White Specify: W	hite
led within 72 h lygiene. her then "nati nt, tre Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ 17. Father's Name (First, Middle, Last)	(Give	edent's Usual Occupation be kind of work done during DO NOT use retired) trical Eng	gineer	g		overnment
and 2 should be filed with and 2 should be filed with leath and Mental Hygiene m 27 is marked other than the traumatic avant, that	To Be	Samuel Rosenthal 19a. Informant's Name/Relationship (Type, Print)	19b. Mail		Fannie	E. Col	nen	p Code)
permit. Pages 1 and 2 Department of Health. Important: if item 27 is any injury or other tra		Boxbara brill With 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	20b. Place of Disp cometery, cre Chesa Peo	Trecan Drosition (Name of ormatory or other place) Kecremator	Da	ite 200	D 20853 Location - City or T	own, State
permit. Pages: Department of himportant: if its any injury or of once.		21. Signature of Funeral Service Licensee MO13	358 9	2. Name and Address of	Facility Ra	ppFune Spring	mu 20910	nation
Physician /Medical		23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition resulting in death) a	he death. Do not en	iter the mode of dying, s	uch as cardiac or	respiratory arred,		Approximate Interval Between Onset and Death
ate be executed as by sician and mysician and into burial-transit	ai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or	consequence of):	Likey	Dise	93 (
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv	very Day Year
quires that quires that an signed b	þ	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause given in	n Part I.	23e. Did tobac	co use contribute to	· /
The law receive hes being page 2 sho	Completed					24a. Was an autopsy performed	prior to ex death?	opsy findings available ompletion of cause of 2 No
VILCIAN: Ilcian: Certific rector,	Be	25. Was case referred to medical examiner?		Othor	6. Place of Death			
Ing Phys	lon: To	27. Manner of Death 1 Natural 5 Pending (Month, Day	28b. Time o	of 28c. Injury at Work?	21	e 5 ☐ Residence Bd. Describe how i	e 6 □Other (Speci njury occurred	<u>fy)</u>
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injurbuilding, etc.	y - At home, farm, si (Specify)		2 No	8f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
na Hospite 24 hours na Funera	edicai C	29a. Certifier (Check only one) 1 Cartifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or in	th occurred at the time, onvestigation, in my opinion	date and place, ar on, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the Vithing Comp	Ň	29b. Signature and title of certifier		29c. License nu	002		Date signed (Mghth.	,
()		30. Name and address of person who suse of de DR Angua (Az / 76) 31. Date filed (Month, Day, Year) 932. Registrar	O Carrol	Print) Ave, Ste	440 Tak	oma Par	K, mD2	0912
Regist	ate rar	_ APR 1 9 2006	IF Ages					

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02457 nrer, Caitlin		Sta 1- For State Registrar	Please T ate of Maryland	ype or Print / Departmen Certificate	t of H	ealth and		giene	Reg. No.	20	06	1227
Physici	an/	Decedent's Name (First, Middle		D 1				2. Date of D Month	eath Dav	Year	3	3. Time of Death
dical Exami	ner	Caitlin 4a. Facility Name (if not institution	Kyle	Rohrer	4h (City Town or Lo	ocation of Death	April 10	, 2006	. County of	Death	13:52
)		Frederick Memorial Ho		,		rederick	ocation of Death			rederick		
Funeral			5. Sex 7. A	ge (In yrs. last birthda		Under 1 Year		8 Date of	Birth (MM	DD/YYYY)	9 Birthr Coun	place (State or Foreig
Director			1 M 2 X F	22	Yrs.	Months Days	Hours Min.	Jan .	31, 1	984	West	t ["] Virginia
od how any <u>ce.</u>	L	Usual Residence of Decedent 10a State 10b. County Maryland Frede	erick	10c. City, Town or L		ζ						0d Inside City Limits
he Marylar or 28a-f s	Director	10e Street and Number 5007 Snow Driv	ve		10	f. Zip Code	21703			zen of Wha		y?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Mar					anic Origin? (Spe Mexican, Puerto R		No-	14. Race - White,		n Indian, Black,
s after ral", o	by F		rced If Yes, Give Year or Dates:			s 2 X No				Specify:	Whi	
hours "natu	ted	 Decedent's Education (Speci Elementary/Secondary (0-12) 	ify only highest grade co College (1-4 or	during			n (Give kind of wo	rk done	16b. F	(ind of Busi	ness/Ind	lustry
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5-U led wi Hygier other	S	17. Father's Name (First, Middle, L	_ast)			18	Mother's Name (First, Middle	e, Maiden	Surname)		
21215-0036 nuld be filed within 7 Mental Hygiene marked other than c event, the Medica	o Be		arry		rer	1	Kath.				Tof	
MD 2 nd 2 should alth and M m 27 is m aumatic of	۲	19a. Informant's Name/Relationshi Kathleen Toft,					and Number or Ru Lace, Fre					
and 2 and 2 Health item 2 traur		20a. Method of Disposition	nother	20b. Place of D	isposition	(Name of ceme		Date		ocation - 0		
mor Pages I ent of I nt: If		1 X Burial 2 Cremation		orematory Mt Oliv			Apr 15	200	6 F1	reder	ick.	Maryland
Baltimore, permit Pages I ar Department of Hee Important: If ite		Donation 5 Other Special Signature of Funeral Service L				-	Facility Basford I	•			,	taly land
Physician /Medical Examiner	er.	25a Part I Enfer the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	omplications that cause in each line. a Multiple Injurie Due to (or as a con b. Due to (or as a con	S sequence of):	nter the m	ode of dying, su	uch as cardiac or r	espiratory	arrest, sho	ck, or hear	Ty Ic	Approximate Interva Between Onset and Death
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con									
e executed sian and rial - transi	lical	UNPENDED	AMENDED									
n of Vital Records, P.O. Box 68760, fing Physician: The law requires that the death certificate be executed. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burnal - transit	Physician/Med	IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	ome of pregnancy 2 at time of death 5	Fetal o	leath 3 (Specify)	Ectopic pregnan	су	230	l. Date of d Month	elivery Day	y Year
. Bc the dea y the a	Phys	Part II. Other significant condition	3 Olikilowii	ath but not resulting in	the unde	dvina causa au	on in Port I	220 Die	d tabasas	una acontribu	ito to the	e cause of death?
, P.O res that t signed by	by	Fart II. Other Significant condition	one contributing to dea	an partior resulting in	ine unde	illying cause giv	eninraiti		_		_	oly 4 🗹 Unknown
Division of Vital Records, P.O. I all or Attending Physician: The law requires that the rs after death all Director: After this certificate has been signed by it led in by the funeral director, page 2 should be detached.	Completed								topsy rformed?	pri de		osy findings available opletion of cause of
al R	a	25. Was case referred to medical					f Death (Check or					
Vita hysici this c	To B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2 🗸 ER/Outpa	atient 3	DOA O	ther 4 Nursing	Home 5	Reside	nce 6	Other:	At .
ion of trending P death tror: After the funer	ation:	27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Date of In (Month, Day Apr 10, 200)	jury 28b. Time (13:00	e of Injury			8d. Describ Priver aut			i	
Division spital or Attent ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rou or Town, State) 4 Homicide (Specify) Major Road / Highway US Rt. 40 @ Brethren Church Rd, F								-		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director,	Medical ((ysician: To the best of one: On the basis of example and manner stated	amination and/or inve								
- > F 0	ž	29b. Signature and title of certifier				29c. License						, Day, Year)
		Theopher &	1. King	nus		O.C.M	.E.		Apri	l 11, 200)6	
07			vho completed cause of Assistant Medical	death (Item 23a)	Penn	Street Balti	more MD 21	201				



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DHMH 17 Rev 1/2001 OCME 10/2003

in of Vital Records, P.O. Box 68/60, ing Physician: The law requires that the death certificate be executed after this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial-transit			
	on of Vital Records, P.O. Box 68/60,	ling Physician: The law requires that the death certificate be executed	Her this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit
	=	=	. 2 3

	7	1 - State Registrar 1. Decedent's Name (First, Middle, Last)			of Death	2. Date of De		3. Time of Death
hysicia		HARRY EDW	ARD RICHARDSON	N .		Month April	Day Year 16, 2006	
/Medica xamine		4a. Facility Name (If not institution, give si	treet and number)	4b. City,	Town, or Location		4c. County of De	
		8725 Oxwell Lane		Lau	ırel		Prince	George's
neral		5. Social Security Number 6. Sex	7. Age (In yrs. last I					irthplace (State or Foreign Country)
ctor		164 30 8966 X	M 2□ F 69	Yrs. Months	Days Hours	Min. (Month, Dan.)		ennsylvania
1		10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
2010.8	ō	Maryland Prince G	eorge's Lau	ırel				1 ☐ Yes 2 ☐ No
	Je C	10e. Street and Number		10f. Zip	Code		10g. Citizen of What C	
	◚	8725 Oxwell Lane		2	20708		U.S.A.	
	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Deced	ent of Hispanic Ori	gin? (Specify Yes or No n, Puerto Rican, etc.)	0- 14. Race - Arr	
,	교	1 Never Married 2 🕅 X Aarried	Armed Forces?			n, Puerto Rican, etc.)		
	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: -1958	1 □ Yes 2	XXo Specify:		Specify: W	hite
	ted	15. Decedent's Educ	ation 16	a. Decedent's Usua	Occupation	t of warting	16b. Kind of Busines	s/Industry
1.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC NCT us	k done during mos e retired)	COL MOTALITY		
	Con		4-years 5+	Actuary			Dept. of	Defense
	a	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name (First, Middle	, Maiden Sumame)	
- 1	ToB	Harry Richardson			Juli	a Kastansky	7	
1		19a. Informant's Name/Relationship (Typ	pe, Print)	9b. Mailing Address	(Street and Number	er or Rural Route Numb	er, City or Town, State,	Zip Code)
		Janet Kay Richards	on / spouse 8	3725 Oxwel	l Lane	Laurel, Mar	cyland 207	08
1	-1	20a. Method of Disposition	20b. Place	of Disposition (Nam tery, crematory or of	e of	Date	20c. Location - City of	r Town, State
1		1 ☐ Burial 2 ☐ Cremation 3 ☐ H 4 ☐ Donation 5 ☐ Other (Specify)	SHIOVALI HOITI STATE	zens Cemet	t t	4/21/2006	Lavelle	Pennsylvani
á		21. Signature of Funeral Service License	A			Yal Home, I		1
KIIK		State SI	/ M00773				el, Marylan	d 20707
		23a. Part1. Enter nie disease, or complic	cations that caused the death. D				The second secon	Approximate
*		shook or xa failure. List only on Immediate cause Final						Interval Between Onset and Death
	I	disease or condition resulting in death)	Parkinson Dise					
ı			Due to (or as a consequence	e of):				
	_	Sequentially list conditions, b.	Dementia Due to (or as a consequence	v. fl				
١.	alre	cause. Enter Underlying Cause (Disease or injury	Case to for the discussions	C 247				
	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):				
;	Medical	d.						
		IF FEMALE:	Bc. If yes, outcome of pregnancy				204 0-1-44	
	Physician/	in the past 12 months?	1☐Live birth 2☐Fetal dea 4☐Pregnant at time of death				23d. Date of de Month	elivery Day Year
	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	3 LI Other (Sp.	<i></i>			
		Part II. Other significant conditions conf	tributing to death but not resulting	in the underlying of	use given in Part I	23e Did	tobacco use contribute	to the cause of death?
	by	3	g	arrasiny ing of	grown and wall			Probably 4 XX Minknown
	tec						100 2010 001	
1	Completed					24a. Was	psy prior to	autopsy findings available completion of cause of
١,	5					perio	ormed? death? 2.200 1 ☐ Ye	es 21XIMo
	Be	25. Was case referred to medical examiner?			26. Place	of Death Check only	one	
- 10	ို	1 ☐ Yes 2 ☆ ☆ O	ospital: 1 Inpatient 2 ER/0	Outpatient 3 DO	A Other: 4 □ Nu	ırsing Home 5XXResi	idence 6 □Other (Sp	ecify)
П.		27. Manner of Death	28a. Date of Injury 28b (Month, Day Year)	Time of 2	3c. Injury at Work?	28d. Describe	how injury occurred	
ij,	유미	1 XXatural 5 ☐ Pending 2 ☐ Accident investigation	(, 22)	м	1 ☐ Yes 2 ☐	No		
ij,	ā	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory	office		Street and Number or F wn, State)	Rural Route Number,
Į,	ificat		building, etc. (opecity)			0.1, 0.1	Wi, Statoy	
- I	Sertifical	4 Thomicide		de, death occurred	at the time, date ar	nd place, and due to the	cause(s) and manner a	as stated.
;	cal Certification:	29a. Certifier 1 Exertifying Phys	ician: To the best of my knowled	and/or investigation	in my opinion, dea			
	Medical Certifical	29a. Certifier 1 Sertifying Phys (Check only one) 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination and manner stated.	and/or investigation,	License number			
1	edical	29a. Certifier 1	er: On the basis of examination	and/or investigation,	License number		29d. Date signed (Mor	nth, Day, Year)
	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier	er: On the basis of examination and manner stated.	and/or investigation,				nth, Day, Year)
	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who could be considered in the cons	or: On the basis of examination and manner stated.	and/or investigation, 29c a) (Type, Print)	License number	8	29d Date signed (Mor	nth, Day, Year)
	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who could be considered in the cons	er: On the basis of examination and manner stated.	and/or investigation, 29c a) (Type, Print) Drive La	License number	8	29d Date signed (Mor	nth, Day, Year)

DHMH 17 Rev 1/2001

			For	State of M	aryland	_				and M	ental Hyg	iene	0.0	10070
			1 - State Registrar	-41\		Cei	rtificat	e of L	Death			g. No:	UÜ	16610
	Physici	an	1. Decedent's Name (First, Middle, La) D	220						2. Date of Deat Month	Day	Year	3. Time of Death
1	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)	0-7-1	-	4b. City,	Town, or	Location o	of Death	09	12 4c. Cou	2006 inty of Death	2+>> 1
	Exam.		Baltimore VA	medical	Certa	er	R	that	imor	e			NIA	
	Funeral		5. Social Security Number 6. S		je (In yrs. las	t birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	Cour	
	Director		Usual Residence of Decedent			113.					Jan. 6,	1926	Mar	yland
	nyland	_	10a. State 10b. County		10c. City, 7	Town or Lo	cation						1	0d. Inside City Limits
	8a-f	Funeral Director		imore				imor	e					1 ☐ Yes 2X No
	with t		10e. Street and Number				10f. Zip		o =		10		of What Cour	•
	leath	era	3310 Benson Aven	12. Was Decedent	Ever in U.S.	13	Was Dece	212		nin? (Spec	cify Yes or No-		ted Sta	
9	after o	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑XYes 2 ☐	,	j —				, Puerto F	city Yes or No- Rican, etc.)		Black, White,	etc.
93	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1953	3	1 🗆 Yes	2LANO	Specify:			Spe	ocify: Wh	ite
<u>7</u>	"nati	lete	15. Decedent's E (Specify only highest gra		1	16a. Deced (Give	dent's Usua kind of wo	al Occupa	ition <i>luring m</i> ost)	of workin	g	16b. Kind o	f Business/Ind	dustry
212	filed within 72 hours after death with the Maryland Hygiele. other then "naturel", or teme 23a or 28e-f ehow the the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	<i>m</i> 0.	Mai	nten	ance Mecha		ľ	Marti: Ma:	n rietta	
밀	al Hyg	BeC	17. Father's Name (First, Middle, Last,								(First, Middle, N	faiden Sun	name)	
yla	Ment Ment Marked	2	Jacob Ruff							Hak				
Mar	d 2 sh th and 7 ie m traum		19a. Informant's Name/Relationship (Route Number,			Code)
re,	s 1 an 1 Heal Item 2 other		Lisa Broccolino - 20a. Method of Disposition		20b. Plac	e of Dispo	Tinda sition (Nar	ne of	nue,		imore, N		206 on - City or To	wn, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at another.		1 Burial 2 Cremation 3 Dopation 5 Other (Specif	Removal from State	West	ereny, crer Aru: mato:	sition (Name natory or o ndel rv	ther place	*/ 4	-17-2	2006	denta	on, MD	
alti	spartn spartn sports ty inju	(21. Sign tu a of Funeral Service Lice	399	11/10			d Addres			rose Fur			Inc.
	20729	/	1 Summer	2 AMAIN	MM	13/27	19 Ha	mmon	ds Fr	y Rd	, Lanso	lowne		227
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.			7		cardiac or	respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	shage			ian	cer					
	Examiner		Convention line and discon	b	u 00/100qu0/1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
	Si Si	lner	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dualto (or as	a hone aquen	ne of):								
	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequen	ice of):						_		
8760	ficate be executed physician and is the burial-transit			ď	•	,								
9	rtificat ng phy as th	Medi	is service									1		
Вох	eath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3	Ectopic pr	egnancy					Date of delive	
o	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as i	Physician/Medical	1 Yes 2 No	4□Pregnant at 9□Unknown	time of deat	h 5□	Other (sp	ecify)					Month	Day Year
ر. ت	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resultir	ng in the ur	nderlying c	ause give	n in Part I.		23e. Did tob	acco use c	ontribute to th	e cause of death?
Vital Records,	w require been sig should b										1 🗀 Ye	s 2 No	3 Prob	ably 4 Unknown
မင် ပ	law n nasbe	Completed									24a. Was an	24	prior to con	osy findings available
											perform 1 Yes 2	No	death? ,	No No
5	nysician: Th	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital:		10		Othe	-		Check only one	Č.		
ö	g Phy er this eral d	\vdash	27. Manner of Death	1 Inpatie	ry 28	Outpatien b. Time of		8c. Injury Work	4 🗆 Nur		e 5 Resider)
Ö	offending death.	atlo	1 Natural 5 Pending investigation		у ғөаг)	Injury	м		? ′es 2 □ N	40				
Division	after de Directe Jin by t	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of Inj	ury - At home c. (Specify)	, farm, str	eet, factory	, office		28	Bf. Location (Str. City or Town,	eet and Nu State)	mber or Rura	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death To the Funerei Director: After this certifica completely filled in by the funeral director,	edical C	29a. Certifier Certifying Ph	ysician: To the best niner: On the basis of and manner sta	examination	dge, death and/or inv	occurred restigation,	at the tim	e, date and inion, deat	d place, ar h occurred	nd due to the car d at the time, da	use(s) and te and plac	manner as sta e, and due to	ated. the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier					. License	400	10		I	ned (Month, L	
)			▶ Woras	to mo				P1	47	14		41	12/20	060
	1021		30. Name a address of person who	completed cause of d	leath (Item 23	Ba) (Type,	Print)			-	street	7	1/2	21201
20	Sta	te.	31. Date filed (Month, Day, Year)	32. Aogistr	ar's Signature	1 (0 10	. 0	reev	ne :	street	, 0	altimo	re, MI)
.8"	Registr		31. Date filed (Month, Day, Year) APR 1 9 (2006	40 All	200		•						

			1 - For State Registrar	State of Marylar		tment of F			giene. Reg. No.	006	12276
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea		V	3. Time of Death
	Physici /Medio		Bassia G	Sossan	Ω			April	15	2006	705 A M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Dea		4c. Co	ounty of Death	
			Renaissance G	acolons To	errace	- Ca	tonsu!	SIL		Balt	more
	Funeral		5. Social Security Number 6. Security Number	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr Hours Mir		h Yourl	9. Birtho	ace (State or Foreign
	Director		242-03-4551	□M 203F 89	Yrs.	Months Days	Hours Mir	April	1,191	7 Nort	h Carolina
-	9		Usual Residence of Decedent								
	how I	_	10a. State 10b. County	10c. Cit	y, Town or Loca	ation				10	Od. Inside City Limits
	B A P A	cto	Maryland Baltimo	re Cat	onsvill	e					1 ☐ Yes 2 🙀 No
	E 2 E	- E	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Coun	try?
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	Funeral Director	715 Maiden Choice	Lane PV116		21228			USA		
		ine	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of H	lispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	- 14.	Race - America Black, White, e	
9	or if		1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give	10	☐Yes 21 No	Specify:		Si	pecify: Whi	
3	filed within 72 hours after Hygiene. sther then "neturel", or ite ent, tre Medical Exertine	d by	3 X Widowed 4 □ Divorced	Year or Dates:							
5	n 72	Completed	15. Decedent's Ed (Specify onfy highest gra	ucation de completed)	(Give ki	nt's Usual Occup ind of work done O NOT use retired	during most of w	orking	16b. Kind	of Business/Inc	lustry
V	P o u	E G	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		ъ		a .
7	Hygie Int.		12. Father's Name (First, Middle, Last)		Sa1	.es	18 Mother's N	ame (First, Middle,		rtment !	Store
	d d d d	Be		O						illanio)	
5	s 1 end 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene is the fire marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	10	Clarence Herbert		10h Mailing	Address (Ctroot		. Litake:		our Ctata Tin	Codel
_	d 2 s th an 7 ier		David B. Sossamon	Son				Washing			
ש	1 end Health em 27 ther to		20a. Method of Disposition		Place of Disposi		LEEL NW,	Date		tion - City or To	0015
5	Pages nent of int: If it		1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crema	atory or other plac					
			4 Donation 5 Other (Specify	<u></u>		Cemete					k, Maryland
0	permit. Depentri Imports eny ink		21. Signature of Funeral Service Licen	See	Fu	neral Ho	ome of C	erling As atonsvil	le, In	nc.	WILZKE
_	40104		Julie	1/000	16	30 Edmor	ndson Av	enue: Cai	tonsv	ille, M	21228
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	n. Do not enter	the mode of dylin	ig, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	a Atherosc	landia	2 carc	BOVOIK	cular o	dice	200	Yours
	/Medical Examiner		resolving in dealiny	Due to (or as a conseq	uence of):						
		-	Sequentially list conditions,	b. Due to (or as a conseq	woman of):						
,	ed Isit	ılne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	derice or).						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):						
Š.	be ey ician buria	a E		333 (3) (3) 33 (3)	201100 017.						
0	phys the	dlcal		d							
XO	ding ding se as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy					. 5	
0	atten atten for u	lan	in the past 12 months?	1☐Live birth 2☐Fete	Ideath 3□E	ctopic pregnancy Other (specify)	,		230	 Date of deliver Month 	ry Day Year
5	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	eath 5 t	Differ (specify)					
ŗ.	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	P.	Part II. Other significant conditions of	ontributing to death but not res	ulting in the unc	lerlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to the	e cause of death?
cords,	sign d be	d by			•	, ,		101	res 2□t	No 3 □ Proba	ably 4 Unknown
5	requ shoul	Completed									
֝֞֝֝֟֝֝֟֝֝֟֝֝֟֝	to to	du						24a. Was autop		prior to con death?	osy findings available apletion of cause of
=	cete							1 ☐ Yes	2 No	1 Yes	25 No
N Ear	isician: The law s certificete has b lirector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		0#		eath (Check only o	ne)		Ageintal
5	this aldir	ဥ	1 Yes 2 No 27. Manner of Death	1 Unpatient 2U	ER/Outpatient	3□ DOA Oth	4 🗆 Nursing	Home 5 ☐ Resid		Other (Specify	一点写
=	After	<u>6</u>	1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	iow injury o	ccurred	O
MISION	death tor:	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	29f Logation /6	Strant and A	lumbas as Clusal	Cause M
<u> </u>	or A offer Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	et, ractory, office		28f. Location (S City or Tou	vn, State)	rumber or Hurai	Houte Number,
-	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1D Certifying Ph	ysician: To the best of my kno	uulodgo dooth	anumod at the same	no data and al-	a and due to the			
	Hos 24 hc Fun stely	lca	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or inve	stigation, in my o	pinion, death occ	curred at the time,	date and pl	ace, and due to	the cause(s)
	ithin o the smple	Medical	29b. Signature and title of certifier	and mainler stated.		29c. Licens	e number		29d. Date s	signed (Month, L	Day, Year)
	⊢≯≓ő		14.14.							\ 15	
	^		1 Mya Ma	completed cause of death (Item	22a\ /T: 7	D 30		F	tpr1	1 10 3	2006
	10				ii zoa) (iype, Pi	C	- منم حا	Ln O	nton	pilla	Mr
	Sta	ite	31. Data filed (Month, Day, Year)	32. Pegistrar's Signa	iture	CICIT		ш 1	CIUI	Byme	1.0
	Registr		APR 1 9 2	200	He And	1 B. B.					

DHMH 17 Rev 1/2001

06-02572 Troy Sheppard

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner TROY ANTHONY SHEPPARD Month Day April 16, 2006 0810 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2303 Bryant Ave Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Foreign 218-78-4302 1 X M 2 F 39 03/08/1967 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. MD BALTIMORE GWYNN OAK 1 Yes 2X No after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1220 HARWALL ROAD 21207 23aUSA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? 2 X No Yes Widowed Divorced Specify: BLACK Yes 2 No specify: ģ es I and 2 should be filed within 72 hours of Health and Mental Hygiene
If item 27 is marked other than "natura her traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12TH CARPENTER HOME IMPROVEMENT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be CALVIN SHEPPARD CORRIE RONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE'MARIA DOLLAR-ALLEN 1220 HARWALL RD, BALTIMORE, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State or other 1 X Burial 2 Cremation 3 Removal from State crematory or other place) ARBUTUS MEM.PK. 4/20/06 BALTIMORE CO., MD Donation 5 Other Specify Juneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, **Physician** Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval e List only one cause on each line /Medical Between Onset and Cocaine and narcotic intoxication dir e Cause (Final disease Death xaminer ition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) Filter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and sician/Medical XUNPENDED AMENDED item#23a,27,28a-f,perME,g855,5/24/06 TT Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 3b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 🗸 Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical the Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other₄ Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other. Scene 2 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Fnd 4/16/2006 Yes 2X No Fnd 8:00 AM 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2303 Bryant Avenue 3 Suicide 6 X Could not be eltimore. To the Funeral (Specify) found at home 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) O.C.M.F. April 17, 2006 30. Name and address of person who completed cause of death (Item 23a) Theodore King MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Ry, Year) State gistrar's Signatu 2006

Registrar

ysicia									2. Date of Dea			3. Time of Death
		David	Snow						Month 04	08	Year 06	1:52 A M
ledica amine		4a. Facility Name (If not institution	. •	*		4b. City, To	wn, or Local	tion of Death		4c. Cou	unty of Death	
		Prince George					erly					Georges
eral ctor		5. Social Security Number 577-50-5384 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Y	ays Ho	nder 24 Hrs. urs Min.	8. Date of Birtl (Month, Day	h y, Year) 3 38		place (State or Foreign ntry) nington, D.C
74		10a. State 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside City Limits
Digital	ctor	D.C.		1	Washing	ton						No 2 No
56.00	Director	10e. Street and Number	C. 17.77			10f, Zip Co				•	of What Cou	intry?
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	by Fun	1 Never Married 2 Mar 3 Widowed 4 Divorced	Amed F	Forces? : 2 ☐ No Bive		If Yes, specify 1 ☐ Yes 2		xican, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	, etc.
icat E		15. Deceden	t's Education	4)	16a. Dece	dent's Usual C	ccupation			16b. Kind o	f Business/fr	ndustry
DOM:	Completed	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work of DO NOT use r	retired)	most of work	ang			
rt E	ပိ	17. Father's Name (First, Middle,		yrs.	CON	MPUTER			- (Circh Middle		Govern	nment
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other traumatic	ပ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Si			al Route Number	r, City or To	wn, State, Zip	o Code)
or trai		Elvera Snow/W	fe						Washingt			
or othe	-	20a. Method of Disposition 1 □ Burial 2 ▼Cremation		n Ctata	Place of Dispo cemetery, crei	osition (Name of	of r place)		Date	20c. Location	on - City or To	own, State
ury o		`4 □Donation 5 □Other (S		Me	etropol	itán Ce	em.	04-2	20-06	Alexai	ndria,	VA.
any injury or once.		21. Signature of Funeral Service	Licensee						shall's Washing			
100		23a. Parti. Enter the disease, or shoots or heart failure. List	complications that only one cause on	caused the dea	ath. Do not ent	ter the mode of	f dying, suc	h as cardiac	or respiratory arr	rest,		Approximate Interval Between
ian		Immediate Cause (Final disease or condition resulting in death)	-a Lll	NG G	ANCE	K						Onset and Death
ical ner		resulting in death)	Due to	(or as a conse	equence of);	CULAR	Ac	PIDE	L			
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a conse		MIAK		CIBEI	V /			
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3 1	EX	resulting in death) Last	Due to	o (or as a conse	equence of);							
the burial transit	dical		d									
detached for use as	/Me	IF FEMALE:	23c. If yes, o	utcome of pregr	nancy					224	Data of deline	on.
	hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	birth 2 ☐ Fei gnant at time of	tal death 3	Ectopic pregr Other (specif				230.	Date of delive Month	Day Year
should be detach		Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying caus	e given in P	Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?
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rector, page 2 s	S								perform 1 Tes	med? 2 No	death? 1 ☐ Yes	2□ No
200	Be	25. Was case referred to medica examiner?	Hospital:				0.1		h (Check only on			
_ F	9	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of		Injury at Work?		me 5 Reside			(y)
e Inu	atio	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	9	nth, Day Year)	Injury		Work? 1 ☐ Yes 2	2 🗆 No				
	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Plac	e of Injury - At I ding, etc. (Spec	home, farm, str	reet, factory, of	fice		28f. Location (Si City or Town	treet and Nu n, State)	mber or Rura	al Route Number,
=	edical C	29a. Certifier 1 Certifyir (Check only one) 1 Medicel	g Physician: To the	ne best of my kr basis of examin	nowledge, deatl	h occurred at the	ne time, date my opinion,	e and place, death occurr	and due to the cred at the time, d	ause(s) and late and plac	manner as s	stated. to the cause(s)
ошфио	_	29b. Signature and title of certifie		ior stated.		29c. Li	cense numb	ber	2	9d, Date sig	ned (Month,	Day, Year)
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11.0		30 Name and address of person		use of death (Ite Registrar's Sign						/		-

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ap^{Mo}i'l 18^{Day} 2006^{Year} 10:20 а м Marjorie Doris Sheehan /Medical 4a. Facility Name (If not institution, give street and number)
1618 Sail Away Circle 4b. City, Town, or Location of Death 4c. County of Death Examiner Essex Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 002-12-7401 Director 78 09/05/1927 New Hampshire Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examinar must be notified at Director Baltimore 1 Yes 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö is marked other than "natural", or Items 23s 1618 Sail Away Circle 21221 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White ģ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Registered Nurse Medical permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9006. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maida O'Brien Joseph Gamache 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Siobhan Sheehan(daughter) 1618 Sail Away Circle, Essex, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Hilltop Svc. Corp. 04/24/2006 Towson. Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 21. Signatu Kucka TowsofaciFuneral Home, 1050 York Rd. Towson, Md. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, so chas cardiac or respiratory arrest shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death should be detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? Yes 2/10 certificate 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: Natural 2 Accident 5 Pending investigation within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of Symination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who of death (Item 23a) (Type, Print) Dr. Akkad 760ď Osíer Drive, Suite 411, Towson, Maryland 21286 32. Registrar's Signature 31. Date filed (Month, Day, Year) 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** M 50, EANE 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CO. OMMODS 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours Min 213-03-5130 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 No DNS 10e. Street and Number 10g. Citizen of What Country? 2/2 16 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H tant: If item 27 is marked ott UNKNOWN INKNOWP 19a. Informant's Name/Relationship (Type, Print) VO KODD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 50N UD. 21204 ON injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of important: If any injury or once. ARMEL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ao min /Medical (or as a consequence of): Examiner HYPMOSCI many year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) P.O. After this certificate has been signed funeral director, page 2 should be detent Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ፩ 1 Yes 2 No 3 Probably 4 Unknown Completed rementic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.
To the Funarsi Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > Cicema Kapa MD D27541 April 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREETHA RHIM MD, 4367 HOllins Ferry 24, 54th 4A, Baltimone, MD-21227 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 9 200\$ Registrar

DHMH 17 Rev 1/2001

	1- For State of Maryl Registrar	and / Department of Health and I Certificate of Death	Mental Hygiene 0 0 6 228
Physician	Decedent's Name (First, Middle, Last) Mary Shonk		2. Date of Death Month Pay Year And And Andrews 3. Time of Death
/Medical Examiner	4a. Facility Name (If not institution, give street and number)	4b_City, Town, or Location of Death	14 dox6 1:347 ^M
	Franklin Square Hosp	ital Kosedale	Baitimore
Funeral Director	5. Social Security Number 15. Sex 7. Age (ħr.) 212-20-2364 1 □ M 2 CXF 80	yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April 16,1925 9. Birthplace (State or Foreign Country) Maryland
and	Usual Residence of Decedent 10a. State 10b. County 10c.	. City, Town or Location	10d. Inside City Limits
Maryi Befeho Ilinda	Maryland Dundalk	Baltimore	1 □ Yes ŽŪ No
State death with the Maryland ritems 23a or 28a-f show where must be notified at Puneral Director	10e. Street and Number 7020 Eastern Avenue	10f. Zip Code 21224	10g. Citizen of What Country?
death death	11. Marital Status 12. Was Decedent Ever in Armed Forces?	in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	
re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan filed at 1 and 2 should be filed within 72 hours after death with the Marylan filed at 1 and 2 should be filed with the Marked other than "naturel", or itema 23a or 28a-1 show other treumatic event, the Madical Exemities must be mailified at To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes MXNo If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.) Black, White, etc. Specify: White
5-00 72 hou nature	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16h Kind of Business/Industry
21215-00 21215-00 ed within 72 hou system. In the Medical E	Elementary/Secondary (0-12) College (1-4or 5+) 12 Years	(Give kind of work done during most of wor life. DO NOT use retired) HOmemaker	Own Home
ind 2 be filed tal Hygi d other event, I	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumame)
aryland be file and Menial Hy e marked oth numatic event	Louis Lombardi 19a. Informant's Name/Relationship (Type, Print)		Patella ral Route Number, City or Town, State, Zip Code)
e, Maryland 2121 1 end 2 should be filed within Health and Mehala Hygiene. 1 enz? ie merked tother than the treumatic event, the Mere treumatic event, the Mere To Be Comp	Mr. Frank Shonk (Husband)		altimore, Maryland 21224
U 00	1 Burial 2 Cremation 3 Removal from State	b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore permit. Pages 1 poperment. Pages 1 important if tel He important if tel He any injury or oth	4 ☐ Donation 5 ☑ Other (Specify) Entombment 21. Signature of Funeral Service Licenses		19/2006 Rosedale, Maryland Home of Dundalk, Inc.
S F G F G G	Just a Jones	7922 Wise Ave. Du	undalk, Maryland 21222
	23a ant. Enter the disease of complications that caused the dishock, or heart failure, list only one cause on each line.	death. Do not enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) Due to (or as a con	idium Ditticile sequence of):	Colifis
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	sequence of):	
executed executed in and inal-transit	that initiated events		
18760, icate be executed physicien and the burial-transit clical Examir	resulting in death) Last Due to (or as a con	sequence of):	
يو هرم ۾ ف	d		
S, P.O. Box 6 set that the death certificated by the attending be detached for use as by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
o.O. In the de by the a tached tached thysic	1 Yes 2 No 9 Unknown	of death 5 Other (specify)	
	Part II. Dther significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacco use cogtribute to the cause of death?
I Record The law requir cate has been s page 2 should	Acute tubular Necro	NS1S	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available
I Rec	Hypertension	023	autopsy performed? prior to completion of cause of death?
f Vital Re yelden: The is certificate he director, page	25. Was tase referred to medical examiner?	Other	th (Check only one)
On of \ding Physin h. After this of funeral directly to the think of t	27. Manney of Death 28a. Date of Injury	28b. Time of 28c. Injury at	ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Sior Itendin death. Itor: Ai the fur	2 Accident investigation	M 1 Tes 2 No	Off Location (Chance Victoria Con Line
Division c tast or Attending P is efter death: all Director: Alter t ed in by the funera Certification;	4 Homicide determined building, etc. (Sp	At home, farm, street, factory, office ecify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attentiviting 24 Hours after death within 24 Hours after death to the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 Medical Examiner: On the basis of exam	knowledge, death occurred at the time, date and place nination and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
To the within 2 To the complex	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	> Wassin Ell-Hith	M D 61251	4/14/06
6	30. Name and address of person who completed cause of death (Bartimore, md 21	n EL-Ailli 037
State Registrar	31. Date filed (Month, Day, Year) 32. Pegistrar's Si	ignature	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#21, perFlocate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 515 Luiz E.R. Soares April 17, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/16/1942 Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F 63 Months 398-56-7243 Director Brazil Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other then "naturel", or iteme 23a or 28a-f ehow sumatic event, the Medical Examinar must be notified at MD Howard Columbia 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10850 Green Mountain Cir. Apt. 119 21044 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Private Industry 2121 Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst filed Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 2018. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luiz Soares Aminta Rosich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OakES Adelaide Soares/Wife 10850 Green Mountain Cir. Apt. 119 Columbia, MD 21 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Apr 18 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives Lynda Sue Ritter-MJ1443 (perIVK) 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Colon Cancu 1000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>۾</u> 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 No of Vital :: After this certifica e funeral director, I Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) NSP (Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

MARON

31. Date filed (Month, Day, Year) APR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHALLES, MD

2006

6601

32. Registrar's Signature

N.C

goods!

29c. License number

DS9303

harts syneet

29d. Date signed (Month, Day, Year)

Barmore ms 21224

18

APRIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 8:35 AM E. Slawie Kathryn 12 2006 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3701 International Drive#417 Silver Spring
If Under 1 Year If Under 24 His. Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days 1□M 2XF Hours 578-36-2431 103 4-14-1902 TOWO Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits montgomerv 1 Tyes 2 No SilverSpring MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3701 International Dr. #41 20906 JSA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 1 4 10 Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sipke I, Koster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3331 S. Leisure World Blvd. Silver Siring MD 20906
ce of Disposition (Name of Date 20c. Location - City or Town, State LOIS Stirling/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4-17-06 Beltsville, MD Chesapeake Cremostory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility Rapp Funeral + Cremation Services 933 Gist Ave. Silver Spring MD 20910 m01358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure to Thrive months Due to (or as a consequence of) Wear. 23d. Date of delivery Month Day Year obacco use contribute to the cause of death? 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? psy ormed? 2 No 2 No 1 ☐ Yes idence 6 Other (Specify) how injury occurred

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifici completely filled in by the funeral director.

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Iteme 23a

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othn any njury or other traumatic event, page.

Physician

/Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funerai

Completed by

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Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Sentitiv Due to (or as a conse c. Due to (or as a conse d.						yeare
nysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 ⊟Ectopic i				23d. Date of de Month	livery Day Yea
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Completed by						24a. Was an autopsy performed?	death?	utopsy findings ava completion of caus
Be	25. Was case referred to medical examiner?			26	. Place of Death	(Check only one)		
2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 (☐ ER/Outpatient 3☐ D	OA Other:	■ Nursing Hor	ne 5 Residence	6 ☐Other (Spe	icity)
	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes	2 □No	8d. Describe how inj	ury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not 1 4 ☐ Homicide determined		nome, farm, street, facto	ry, office	4	28f. Location (Street a City or Town, Star	and Number or R. te)	ural Route Number
Medical Certification:	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examir and mannar stated.	nowledge, death occurre nation and/or investigation	d at the time, d n, in my opinio	late and place, a	and due to the cause(: ad at the time, date an	s) and manner as nd place, and due	s stated. e to the cause(s)
M	29b. Signature and title of ceriffier	1//	M) 7	9c. License nu 3045	mber		ate signed (Mont	

State Registrar 31. Date filed (Month, Day, Year) APR 1 9 2006

Nakul Groyal

30. Name and address of person 🔻 o 📑 pleted cause of death (Item 23a) (Type, Print)



		_	For State Registrar	State o	of Marylan		artment o			, ,	jiene leg. No.	06	122	85
- 7	Physici: /Medic	al	1. Decedent's Name (First, Middle Julia Agnes Su	mmers						2. Date of Dea Month April	11, 20		3. Time of 7:05	Death A M
	Examin	er	4a. Facility Name (If not institution Frederick Men					n, or Location erick	of Death			ty of Death rederi	ck	
	Funeral Director		5. Social Security Number 220-42-5687	6. Sex 1 □ M 2√ F	7. Age (In yrs.	last birthday) 37 Yrs.	If Under 1 Ye Months Da		24 Hrs. Min,	8. Date of Birth	191 8		olace (State o	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State Maryland Tree	derick	10c. Cit	y, Town or Lo	Frede	ick				1	0d. Inside Ci	-
	th with the 23s or 28s	Funeral Director	10e. Street and Number 236 East Churc	h Street			10f. Zip Cod	2170)1		10g. Citizen o	f What Cour	ntry?	
036	should be filed within 72 hours after death with the Maryland d Mental Hygiene. marked other than "natural", or liems 23a or 28a-f ahow marked other than "natural", or liems 23a or 28a-f ahow marke ovent, tra Modical Examinar must be notilised at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒Widowed 4 ☐ Divorced	ned 1 ☐ Yes	2 1 X No		Was Decedent of Yes, specify 0			ecify Yes or No- Rican, etc.)	14. Ra Bl Spec	ace - Americ ack, White, ify: Whi	etc.	
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Maryland 2	m = 0 5	To Be Co	17. Father's Name (First, Middle, Howard	C. Murphy						(First, Middle, ne Agne	Maiden Suma	ame)		
	permit. Pages 1 and 2 should by Oppurment of Health and Menta Important: If Item 27 is marked any Injury or other traumatic events.	1 8	19a. Informant's Name/Relations Judith S. Camp			106-4	A East S	Second	Stre	et, Fred	derick	, MD 2	21701	
Baltimore,	t. Pages 1 rtment of H rtant: If ite njury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	Stalledt Of	emetery crep LIVET (sition (Name of natory or other Cemetery	A	pril	17, 20		ederio		ryland
Ba	Department of the control of the con		21. Sin ture of Funeral Service	. C. Has	MOO		106 E	ast Chu	rch :	rd Fune: Street,	Frede	ne cick,	MD 21	
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مَ	w requires that the back of the by should be detack	by	Part II. Dther significant conditi	ons contributing to d	leath but not res	ulting in the u	nderlying cause	given in Part I			bacco use co		ne cause of d	
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<u>=</u>	ysician: Th s certificate director, pag	o Be	25. Was case referred to medica examiner? 1 Types 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA	0.1		(Check only or me 5 ☐ Resid		ther (Specifi	v)	
Division of Vital	To the Hospital or Attending Physician: The within 24 bours after death. withe Funeral Director: After this certificate his completely filled in by the funeral director, page	ation: T	E	28a. Date (Mon gation	of Injury oth, Day Year)	28b. Time of Injury	28c. l	njury at Vork?	2	28d. Describe h			,,	
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	To the Hospital within 24 hours a To the Funeral I completely filled	edicai	29a. Certifier (Check only one) Certifyii 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno pasis of examina nner stated.	wledge, death tion and/or in	occurred at the vestigation, in m	a time, date ar ly opinion, dea	nd place, a oth occurre	and due to the c and at the time, d	ause(s) and n late and place	nanner as s o, and due to	tated. the cause(s	;)
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•	101		30. Name and address of person		se of death (Item	23a) (Type,	Print)	سر میسی	- (-	Fre	1-10-	16)	817	6/
	N V		31. Date filed (Month, Day, Year,	6403	Registrar's Signa	501	W 7	2	c-	1	uro	c5 1		

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death					12286	
- 4	9.4	ÿ	1. Decedent's Name (First, Middle, Las	i)	,		2. Date of Death		3. Time of Death
	Physici /Medic		Garne	++-	Sita	ellinas	April	Day Year	∂:30 M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Deat		4c. County of Death	1
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	Funeral	150	5. Social Security Number 6. S	9x 7. Age (In yrs.	Months	r 1 Year If Under 24 Hrs Days Hours Min.	(Month, Day, Y	ear) 9. Birthp	lace (State or Foreign
100	Director	Funeral Director	22910 30 34 1 1 1 1 9 9 Usual Residence of Decedent						
	/land		10a. State 10b. County	10c. Cit	y, Town or Location			1	Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23s or 28s-f show eny injury or other treumatic event, the Modical Examitment the notified at once.		mo Hour		siderala				10 Yes 2 □ No
			10e. Street and Number		10f. Zi	p Code	10g	. Citizen of What Cour	itry?
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		nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (S scify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	an Indian, etc.
		by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give		214 No Specify:		Specify: \	Maile
		To Be Completed t	15. Decedent's Ed	Year or Dates:	16a. Decedent's Usu	al Occupation	16	b. Kind of Business/Inc	//// T
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21			12	College (1-4or 5+)	Hom	e maker		Dormes	tic
			17. Father's Name (First, Middle, Last)	11 1.		18. Mother's Nar	ne (First, Middle, Mai	iden Sumame)	
yla			William	Hudson		General	1 Dran	+	
Maryland			19a. Informant's Name/Relationship (ype, Print)	19b. Mailing Addres	s (Street and Number or Ru	ral Route Number, C	city or Town, State, Zip	Code) 21044
			20a. Method of Disposition	20h B	Place of Disposition (Na	De JOS CAR	Date 200	c. Location · City or To	bigInD
jor			1 Burial 2 Gremation 3	Removal from State	cemetery, crematory or	other place)	37 1	2. Man	MII, State
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify 21. Signatu ☐ uneral Service Licen		22 Name a	nd Address Facility	CC-44 1	salto,	1011)
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300			23a. Part1 Enter the disease, or comp	olications that caused the deat	h. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest	- S1678 CD	Approximate
	Hospital or Attending Physician 4 hours after death. Funarel Director: After this certifi ely filled in by the funeral director	Physician/Medical Examiner	Immediate Cause (Final						Interval Between Onset and Death
			disease or condition resulting in death)	a. Due to (or as a consequence of):					
			Sequentially list conditions	b. Preumana					
			Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury	Due to (or an a consequence of):					
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8760,				Due to (or as a consequence of); d.					
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Box 6			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of delivery	
Ď.		lcia	in the past 12 months? 1 Yes 2 No	1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)			Month	Month Day Year	
Division of Vital Records, P.O.		hys	9 Unknown						
		þ	Part II. Other significant conditions of	ontributing to death but not res	cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
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		Be Completed		24a. Was an autopsy			24b. Were autopsy findings available prior to completion of cause of		
				performed? death? 1 Yes 2 No 1 Yes 2 No					2 □ No
			25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Placed and the control of the control					
		i. To	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred					
		atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation						
		Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, tarm, street, factory, office 28f. Location (Street building, etc. (Specify) 28f. Location (Street City or Town, Ste			t and Number or Rural Route Number,		
			29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examine: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. and manner stated.						
	To the within 2 To the complet		and manner stated. 29c. License number 29d. Date signed (Month, Day, Year						
)	⊢≯⊬ٽ		1 /20 /1	750870		A	April 18th 2004		
	B		30 Name and address of person who	completed cause of death (Item	23a) (Type, Print)	11/1:	61 - 1	11/1/11	1) 22000
	9		29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) April 18th 2004 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SUZAN Abdu 5005 Signature Name Sell Land Clashsull MD 21029						
	200	A.	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture /				
12.5	Sta Registr		ARR 1 9 200	. H. L. M.	Section 1				

SchuMacher

Cymond

Death

Year

2 No

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State)
500 Blk. Sheridan Avenue, Baltimore, Md.

April 9, 2006

Director: the

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: 24 hours a

State Registrar

Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

Suicide

4 V Homicide

APR 1 9 2006

Could not be

30 Name and address of person who completed cause of death (Item 23a)



(Specify) Local Street

and manner stated

Assistant Medical Examiner

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Deposite Name Private Deposite Depos				State	or Mary	•	rtificate of	neaith and iv Death	•	Reg. No.	6	12289
Charles George Traithrein (April 18.2006 10:35 AM Partity New Order during interface, plus seems and orders) Hamilton Nursing Center Formal Partity New Order during interface, plus seems and orders) Social Security Number (2.500 and S				1. Decedent's Name (First, Middle, Last)					2. Dete of Dee	eth	V	3. Time of Death
As Pecially Name of the contraction of pecial Plannia Line Nursing Center Part Hamil Line Nursing Center Security Number Security				Charles Ge	orae	Tra	utwein					10:35 AM
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Top Siles Top County WA Baltimore Top County WA Baltimore Top County WA Baltimore Top County WA Baltimore Top County WA Baltimore Top County Top County Top				213 03 0403	7. Age (In			Hours Min.	8. Date of Birth Month, Day July 2,	.908 ⁽¹⁾	9. Birthe Cour Mary 1	place (State or Foreign and
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Physician Medical Examiner The disease of conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease of condition resulting in death) The disease of condition death of the disease of condition resulting in death) The disease of condition death of the disease of condition resulting in death) The disease of condition death of the disease of condition resulting in death) The disease of condition death of the disease of conditions resulting in death) The disease of condition death of the disease of conditions resulting in death) The disease of conditions death of the disease of conditions resulting in death) The disease of conditions death of the disease of cond	m	20 2 2	1	Christina L. Hill	m	1.	onard .	Ruck In			•	
Physician Modical Examiner The part of t				23a. Part1. Enter the diseese, or complications the shock, or heart failure. List only one cause of	at ceused the on each line.	death. Do not en	ter the mode of dyi	ng, such as cardiac o	or respiratory ar	rest,	u ne	Approximate Interval Between
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	ŏ	th cer tandir r usa	ar/	d	1010	10 (17)						
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The state of the s	<u>o</u> .	nat th	된	HYPERTENSIA	A (·				101	es 2 ⊠No	3 ☐ Prol	bably 4 Unknown
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ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Ldq		Tes+9		2. Date of Month	Da Da	Year LDOG	3. Time of Death
	Examir		4a. Fecility Name (If not institution, give, street and number)	oital	4b. City, Town, or	Location of I			County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 011-27-1478 1□ M 2♥ F 78	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mont	h. Dav. Year	9. Birth	place (State or Foreign intry) achusetts
	yland how		Usual Residence of Decedent 10a. State 10b. County 10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	r 28a-f s	Director	Maryland Baltimore		10f. Zip Code	Dund	lalk ————	10g. Ci	itizen of What Cou	1 ☐ Yes 2 ₹ No intry?
	23a o	rai D	1803 Homberg Avenue			2122			nited Sta	ates
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Madical Examinating the mollified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes Cive Year or Dates:	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin in, Mexican, F Specify:	n? (Specify Yes o Puerto Rican, etc	or No-	14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	rithin 72 hc ne. nan "natur e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired Omemaker	ation during most o l)	f working		(ind of Business/le	ndustry
ind 21	d tal	Be Co	8 Years 17. Father's Name (First, Middle, Last)	110	DINEMAKET		Name (First, Mi	iddle, Maider		
<u> </u>	should nd Mer marke	은	Pasqule Massi 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	and Number o	or Rural Route N	umber, City	or Town, State, Zi	p Code)
, Ma	ges 1 and 2 should it of Health and Men it item 27 is marke or other traumatic		Debra Fisher (Daughter)	790	O Rolling		Ave. Ba	ltimo	re, Maryl	land 21236
more	Pages 1 nent of H int: If itel iry or oth		1 Burial 2 X Cremation 3 Deemoval from State		sition (Name of natory or other plac Service (Date 4/17/200	1	ocation - City or T DWSON , Ma	
Balti	permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Licensee	22 D	Name and Address uda-Ruck 922 Wise	ss of Facility Funer	al Home	of Du		
			23a Art1. Enter the diseast or complications that caused the dea shock, or heart failure. List only one cause on each line.						/Idikt ZIZ	Approximate Interval Between Onset and Death
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rds, P.	The law requires that the te has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not re-	sulting in the un	derlying cause give	en in Part I.			use contribute to t	he cause of death?
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Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Η,	1 Yes 2 No 10 Nation 2 2 27. Naponer of Death 2 2 27. Naponer of Death 2 2 28a. Date of Injury (Month, Day Year) 2 Accident investigation	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 🗆 140131	28d. Desc	Residence ribe how inju	6 ☐Other (Special ry occurred	fy)
DIVIS	spital or Attandii ours after death. teral Director: A filled in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined building, etc.)	lome, farm, stre	et, factory, office	D16		on (Street ar r Town, State	nd Number or Rura e)	al Route Number,
	ne Hospital n 24 hours ne Funeral pletely filled	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my km one) Medical Examiner: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	ne, date and pointion, death	place, and due to occurred at the ti	the cause(s me, date an) and manner as s d place, and due to	stated. o the cause(s)
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	Physicia		1. Decedent's Name (First, Milo	U16, L231/	The	1	25 00		AOVI	4 200 G	10:45 AM
	/Medic	al	4a Facility Name (If not instituti	ion give street and number	1 1/0	26/X	4b. City, Town, or	Location of Deal		4c. County of Dea	
d.	Examin	er	Pala-P	On-1- OI		304	125612	- RAIL	15 any	ZU BA	th. Cita
	Funeral		5. Social Security Number	6. Sex V. As	ge (In yrs. last		If Under 1 Year	If Under 24 Hrs		h 9. Bir	thplace (State or Foreign
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	ס		Usual Residence of Decedent								10d. Inside City Limits
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	er de	Funerai	11. Marital Status 1 □ Never Married 2 □ M	Armed Forces	?	If If	Yes, specify Cubai	n, Mexican, Puei	to Rican, etc.)	Black, Whi	te, etc.
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4	/Medical		disease or condition resulting in death)	Due to (or a	s a consequen		1101				
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	ecute and trans	Exami	that initiated events resulting in death) Last	c. Due to (or a	s a consequen	ice of):					
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687	# × #			d							
×	eath certificat attending phy I for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			L Color and an			23d. Date of d	alivery
Вох	death a atter	Physician/Med	in the past 12 months?	4□Pregnant	2 Tetal de at time of deatl		Ectopic pregnancy Other (specify)			Month	Day Year
0.	that the de led by the a detached t	hys	9 ☐ Unknown	9□ Unknown							
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of Vital Records,	e law re has be je 2 sh	Completed	hyperter	15161			· · · · · · · · · · · · · · · · · · ·		24a. Was autor	an 24b. Were a prior to death?	utopsy findings available completion of cause of
<u> </u>		 မြ	l .						1 ☐ Yes	2 1 Ye	
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to med examiner?	Hospital:			Oth	05	eath (Check only o		
of	Phys this aldii	2	1 Yes 2 No 27. Manner of Death	1 □ Inpa		VOutpatien	3 DOA	4 Mursing		dence 6 Other (Sp how injury occurred	ecity)
E	After fune	5 E	1- Natural 5 ☐ Per	28a. Date of In (Month, E	ay Year)	Injury	28c. Injun Wor M 1 🗆	k? Yes 2∐No			
Division	Attendide death.	fica	3 ☐ Suicide 6 ☐ Cot	uld not be 28e. Place of I	njury - At home	e, farm, str	eet, factory, office		28f. Location (Street and Number or I	Rural Route Number,
Ö	s effer s effer of Dire	Certification:	4 Homicide	building,	atc. (Specify)				City or To	wii, State)	
	To the Hospital or Attending within 24 hours effer death. To the Funaral Director: Affer completely filled in by the fune	Medical	29a. Certifier 1 Certifier (Check only 2 Media	fying Physician: To the bes cal Examiner: On the basis and manner:	of examination	edge, death n and/or inv	occurred at the tire restigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
_	To th within To th compl	Me	29b. Signature and title of cert	tifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
			Ino	Wy Ohn	10		103	12105	<u></u>	April 13	2006
			30. Name and address of pers	_ t3 2			Print)	1 Roll	Lucario	manila	in O
			31. Date filed (Month, Day, Ye	11.	0 WES		7(16	VIDE	Larion	7779	ril)
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			1 - For State Registrar	State of M	larylar		artmen rtificate			and M	ental Hy	giene Reg. No	211111	Ĵ	12292
	Physici	an	Decedent's Name (First, Middle, La								2. Date of De Month	aath Da	y Yea	ar.	3. Time of Death
	/Medi		* CVIII	TURNER							APRIL	1	7 20	06	5:00 A M
7	Examir	ner	4a. Facility Name (If not institution, giv		CENT	-60	4b. City,		Location o		\sim l		County of D		R L
-	Funeral		5. Social Security Number 6. S	ex 7. A		last birthday)	*		If Under 2						ace (State or Foreign
	Director		218-36-7058	M 2□ F	63	Yrs.	Months	Days	Hours	Min.	8. Date of Bit (Month, Da MAY 29	194 194		Count	MD
	p ,		Usual Residence of Decedent 10a. State 10b. County		140- 07	-									
	ehor ed a	5	MD BALTIM	IORE	100.01	ty, Town or Lo BAI	LTIMOF	RE						10	d. Inside City Limits
	the A	Director	10e. Street and Number				10f. Zip					10a Cit	izen of What	Count	1 Yes 2 No
	3a or	0	7204 CROYDON					21207	,				JSA	Count	ı y r
	death	Funeral	11. Marital Status	12. Was Deceden			Was Deced	lent of His	panic Orig	in? (Spe	cify Yes or No		14. Race - A		
ထ္ထ	or fte	/Fu	1 ☐ Never Married 2K Married	Armed Forces 1 ☐ Yes 2 🔀 If Yes, Give			rres, spec 1 🗌 Yes 2		Specify:	, Риепо і	Rican, etc.)		Black, W		tc.
21215-0036	72 hours after death with the Maryland Insturel', or items 23a or 28a-1 ehow dical Examinar Linet Le multied at	d by	3 Widowed 4 Divorced	Year or Dates:	:								Specin o Li	101	
15	n 72 n nat	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. Deced	dent's Usua kind of wor DO NOT us	il Occupa rk done di	tion <i>uring</i> most	of workir	ng	16b. K	ind of Busine	ss/Indi	ustry
212	iene.	що	Elementary/Secondary (0-12)	College (1-4or	5+)	PRINC						BALT	o. ci	ry :	SCHOOLS
פ	e filed al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle				
ylaı	Menta Menta arked	To E	FRANCIS TURNER							BLAI	NCHE M	IOSEI	ĽΥ	_	
Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinatinal Lambiliad at Ance.		19a. Informant's Name/Relationship (MARGIE L. TURNER/								I Route Numb LTO., M			a, Zip (Code)
ore,	es 1 e of He of He fitem r othe		20a. Method of Disposition	Damarral from Chat-		Place of Dispo cemetery, cren)	D	ate	20c. Lo	cation - City	or Tov	n, State
Ĕ	Pages ment of ant: if it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		KIN	IG MEMO			1	4/22,			IMORE,		
Baltimore,	Departimport		21. Signature of Funeral Service Licer	isee (, Mor)	tin	22					BALTIM				F.H., INC
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the deat	h. Do not ente	er the mode	e of dying	, such as c	cardiac o	r respiratory a	rrest,			Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. GASTRO	INTES	TINAL	MA	LIGI	VANT	7	umor				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as											
		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a conseq	uence of):								+	
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58760,	res that the death certificate be executed igned by the attending physicien and be deteched for use es the burial-transit	edical	(d										_	
	entific fing p	Med	IF FEMALE:	20 11											
P.O. Box	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic pre					2	23d. Date of o Month		/ Day Year
o	the d	yslo	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	it tillie or u	eath 5L	Other (spe	эспу)							•
٣.	s that	by Pr	Part II. Other significant conditions c	ontributing to death I	but not res	ulting in the ur	nderlying ca	use giver	in Part I.		23e. Did t	obacco u	se contribute	to the	cause of death?
rds	quire;	q pa	PERFORATION	06 5	MAL	L 3	Jino				10	Yes 2	□No 3□	Proba	oly 4 Unknown
ပ္တ	law requir es been si 2 should l	Completed									24a. Was		24b. Were	autops	sy findings available
ž	The lav ate hes page 2	E									autop perfo	osy med? 2KI No	prior t death	?	oletion of cause of
ĬĮ	cien: ertifica ctor,	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	-			
5	hysic this co	၉	1 □ Yes 2 X No	Hospital: 1 Inpati		ER/Outpatien			4 🗀 1901:	sing Hom	e 5 ☐ Resid	dence (3 □Other (Sp	oecify)	
n C	Jing F	io	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		Work?			8d. Describe t	now injury	occurred		
Division of Vital Records,	of or Attend after death Director:	flcat	2 Accident investigation 3 Suicide 6 Could not be		iury - At ho	ome farm stre	M et factory		es 2 □N		8f Location /	Street and	d Number or	Qural	Ro <i>ute Number,</i>
à	To the Hosuitel or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Furreatal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be deteched for use e.	Certification:	4 Homicide determined	building, e	tc. (Specif)	y)	out, factory,	Onice		-	City or Tov	vn, State,)	nurari	nodie Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medica	Chack only 2 Wedical Exam	ysician: To the best	of examina	wledge, death tion and/or inv	occurred a	t the time	, date and nion, death	place, a	nd due to the	cause(s)	and manner place, and d	as stat	ed. he cause(s)
	thin 2 thin 2 or the	Med	one) 29b. Signature and title of certifier	and manner si	ated.			License							
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-			to Name and account or person who	I ompleted barrier M.	Xour	Stal Secure		100	45.00	77.57	DUTAL	7.4	ME	~	
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			1 - For State Ragistrar	State of Maryland		artment tificate			nd Me		giene Reg. No.)6	12293
	Physici	an	1. Decedent's Name (First, Middle, Last) MOSES H •	TAYLOR						Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s			4b. City, T	own, or	Location of		PRIL		nty of Death	5:13 A M
	LXamii	ICI	SINAI HOSPITAI				LTIM						
	Funeral Director		5. Social Security Number 229-07-9644 6. Sex Usual Residence of Decedent	7. Age (In yrs. In 86	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hours	Min.	Date of Bir (Month, Da UG. 3	th y, Year) 0, 191	9. Birth Cou	place (State or Foreign intry) VA
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits
	Ba-f s	ecto	MD BALTIMO	RE CATO	NSVILL								1X Yes 2 □ No
	3a or 3	I Dir	10e. Street and Number 22 SHIPLEY AVENUE			10f. Zip (2122	8			10g. Citizen o	USA	untry?
036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Items 23a or 28a-f show avent, I're Madical Evarinar must be natilised at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Agned Forces? 1-11 Yes 2 □ No If Yes, Give Year or Dates: 1942		Was Decede f Yes, specif		panic Origi , Mexican, Specify:	in? (Specifi Puerto Ric	y Yes or No an, etc.)	В	lace - Amer lack, White cify: BLA	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur ne Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give life. l	dent's Usual kind of work DO NOT use WORK	done du retired)	aring most o	of working		16b. Kind of	Business/li	,
/land 2	d tal	To Be Co	17. Father's Name (First, Middle, Last) CALVIN TAYLOR							First, Middle, HOLME	Maiden Sum S	ame)	
	D = 5 = 5		19a. Informant's Name/Relationship (Tyr. YVETTE YARBEROUGH/	oe, Print) GRANDDAUGHTER		-					er, City or Tow LLE, M		. ,
altimore,	0 0		20a. Method of Disposition 1XXurial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State GAR	ace of Dispo emetery, cren RISON	FORES	T V.			6	20c. Location	MILL	s, MD
Balt	permif. Pag Departmenf Important: I any injury o		21. Jona ure of Funeral Service License	Worten	I	BALTIM	ORE,	MD	1701	LAURI	ENS STR		S F.H., INC
8760,	The law requires that the death certificate be executed was required to the aftending physician and uippersonable 2 should be detached for use as the buriat-transit	dicai Examiner	23a. Fart1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	di. pence of): pence of): ntence	6T \	10	of so	reat	NOI			Approximate Interval Batween Onset and Death
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Divis	tal or Attandi rs after death. al Diractor: A ed in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory,	office		28f.	Location (5 City or Tox		mber or Rur	al Route Number,
	To tha Hospital or A within 24 hours after To the Funaral Dira completely filled in b	edical	(Check only 2 Medical Examin one)	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	estigation, i	n my opi	nion, death	place, and occurred	at the time,	date and place	e, and due t	to the cause(s)
	To T com	Σ	29b. Signature and title of certifier				License		5 .		29d. Date sigr	ned (Month,	Day, Year)
1			30. Name and address of person who cor	moleted cause of death /Itom	23a) /Tuno	Drint\		1660			04/1	7/0	16
41	9			"Cimil MD	2600	Libe	Hy	Heigh	n ts An	PERME	Baltin	MORE	MD 21215
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 9 21	32. Registrar's Signat	ure A	garle	,	1-					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Woodland - Evans 2:06 PM Michelle 90 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3814 Baltimore N Hameda ne If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗡 F Months Days Maryland 51 216-58-3106 Yrs. 6-28-1954 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 **S**Yes 2 □ No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3814 A21 21218 or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status parmit. Pages 1 and 2 should ba filed within 72 hours after c Department of Health and Mentat Hygiene. Important: If item 27 is marked other then "netural", or Iten any injury or other traumatic event, the Medical Examination. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1□ Yes 2 Ho Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Administrator 12th grade Years 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Marc Drain Clantor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cross Erica woodland daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04.18.06 ` 4 ☐ Donation 5 ☐ Other (Specify) andall town 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 🔾 anghin Ullus 4905 York red. Bayto. 21212 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metastalic disease or condition resulting in death) 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate ba executa the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown Ď Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 1 No certificate has 210 No Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of 28d. escribe how injury occurred Certification: After Injury 1 Natural 2 Accident 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a, Certifier completely (Check only one) within 2 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) D53070 30. Name and address of peon who completed cause of death (Item 23a) (Type, Print) 1650 15914 Ov 1cans 31. Date filed (Month, Day, Year) Registrar's Signature State 9 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 2006 Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba 1500 more Under 24 Hrs 9. Birthplace (State or Foreign Country) Social Security Number last birthday) **Funeral** 1 M 2□F Days Min. 215-70-483 Months Hours Director Usual Residence of Decedent 10c. City. State Town or Location 10d. Inside City Limits worde ! the Medical Examiner must be notified at Itimore. 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or son Menue Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. 11. Marital Status Race - American Indian. Armed Forces:
1) Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use regred) 15. Decedent's Education fy only highest grade completed) Qry (0-12) pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other then any njury or other traumatic event, the Manay njury or other traumatic event, the Manay njury or other traumatic event, College (1-4or 5+) ommitment & orre Father's Name (First, Middle, Last) Be ex 9a. Informant's Name/Relationship 19b. Mailing Address (Stre Baltimore, Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L Services 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heaft failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Azzi denT Ecrebro ascular /Medical Due to (or as a consequence of): **Examiner** 5 years Hyperten SION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached t P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۾ cete hes been sig , page 2 should b 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete hes tuneral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: al or Attending F after death. I Director: Atter d in by the tunera Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dea To the Funeral Directo completely tilled in by th 3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospite Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10057281 06 mr. 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osei-Boatena Kwabena 827 LINDEN Ave Balhine MD 21201 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death bnth **Physician** 2:30 A M -2006 /Medical 4c. County of Death street and number) 4b. City, Town for Location of Death Examiner Battimore 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕶 F Yrs Director Usual Residence of Decedent State wn or Location 10d. Inside City Limits or items 23a or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "naturel", or items 23a or 28a-1 ehov ury or other traumatic event, It a Macical Exaculter must be notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 21208 Koac 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Glac 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO Not use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1-4or 5+) OOK 18. Mother's Name (First, Middle, Maiden Sumame) Father's Name (First, Middle, Last) vens 19b. Mailing Add ss (Stre State, Zip Code) 20b. Place of Disposition (Name of Method of Disposition 1 Durial 2 ☐ Cremation permit. Page Department o Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signs tore of Fune a Service Licensee Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. for live Immediate Cause (Final disease or condition resulting in death) years **Physician** /Medical Due to (or as a consequence of): Examiner ard www opathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseq ence of) The law requires that the death certificate be executed be detached for use as the burial-transit and Due to (or as a consequence of): Box 68760. Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☒ No 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probebly 4 Munknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificate 2 🗆 No 1 Yes 2 No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Naturaf 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) How yn 141). atharing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPIC Michan 2. Registra s Signature 31. Date filed (Month, Day, Year) State APR 1 9 2006 Registrar

				ype or Print in				•	•	
			For State Registrar	State of Maryla		artment of F rtificate of		ental Hygle Reg.	211110	12297
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
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	Examin		4a. Facility Name (If not institution, give st		,	4b. City, Town, o	r Location of Death	7	4c. County of Death	
			The John Hopk	:15 HOSY	ital	BAHin.	ord			
	Funeral		5. Social Security Number 6. Sex	17. Age (În y M 2-⊋F	rrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo		place (State or Foreign intry)
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	yland		10a. State 10b. County	10c.	City, Town or Lo	ocation		<u> </u>		10d. Inside City Limits
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	filed within 72 hours after death with the Maryland Hygiane. ther then "neturel", or Items 23e or 28e-f show ant, It e Medical Evaruiner must be notified at	Directo	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	untry?
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and	ntal F ed ot ed ot	Be	John H. Johnson							
Maryland 21215-0036	2 should be and Mental Is marked oraumatic eve	2	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Maili	na Address (Street	Ericka D.		S tity or Town, State, Z	in Code)
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ē,	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition	20	b. Place of Dispo		. D		c. Location - City or 1	own, State
Ë	Pages nent of int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ② Other (Specify)	emoval from State	000,0,7, 0.0.	matery or earler pra-				
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21 Signatury of Funery Service Licenses		tor S	2. Name and Addre	tomy Board	1 655 W.	Baltimore	Street
	40 = 0 a	-	23a. Part1. Enter the disease, or complic	rations that caused the c	\ I	Baltimore	, MD 21201			Approximate
	E		shock, or heart failure. List only one	e cause on each line.	noath. Do not on	1	1000			Interval Between Onset and Death
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m	death e atte	iclaı	in the past 12 months?	1 Live birth 2 ☐ F 4 Pregnant at time		□Ectopic pregnanc □ Other <i>(specify)</i> _	y 		Month	Day Year
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a	n: Th licate r, pag		05.114					1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 □ No
Ĭ	sicia: certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatie	nt 3 DOA Ctt	26. Place of Death		e 6 □Other (Spec	ih/)
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Division of Vital Records, P.O.	f or Atte after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, st	reet, factory, office	2	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
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	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	<u> </u>		29c. Licens	se number	29d	. Date signed (Month	, Day, Year)
			Moulde	Chall		D5	6943	4,	pa: 10, 7	2066
			30. Name an address of person who cor	1 =	(Item 23a) (Type	Print)	1 12.1	(1/1.1.	2066
		10	31. Date filed (Month, Day, Year)	32. Registrar's S	M. W.C	Ite STLE	6+ BAH	+. MORE, I	MHCY 19/KI	477
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFH, 0854, 4/28/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 430 PM 4a. Facility Name (If not institution, give street and number 16 5000 Werber /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Cathosille
If Under 1 Year | If Under 24 Hrs. Baltimore Renoussance Gardens Social Security Number Birthplace (State or Foreign Country) 6. Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Yrs Director 88 Sept 24, 1917 New York 090-14-7905 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic evant, the Medical Exercises must be notified at 1 ☐ Yes 2√2 No Catonsville Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21228 United States Itams 23a 711 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White þ 3 NWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 h and Mental Hygiene. 7 is marked othar than "na Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Penders Katherine Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is rr any injury or othar traurr ang. Virginia W. Hartmuller - child 12005 Grayton Run, Ellicott City, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🛣 Removal from State Long_Island National 4/21/2006 Farmingdale, New York 4 □ Donation 5 □ Other (Specify) Cemetery
22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Gastrointestinal hemorrhage disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To tha Hospital or Attanding 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 6 Could not be 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30989 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My M Caros nter
31. Daty filed (Month, Day, Year) 32. MD 711 Marden Choice Ln Catorioville 32. Registrar's Signature State Registrar 2006

ORIGINAL

			1	For State Registrar	State of Ma	arylan			of Healt of Dea			Reg. No.	006	12299
				1. Decedent's Name (First, Midd	le, Last)						2. Date of De	ath Day	Year	3. Time of Death
		Physicia /Medic	al	CATHE		r wh	YTE				Horil	16	2006 County of Death	1010
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-				Citizens	Dursing	HOI	ne last birthda	If Under	VIC Of	nder 24 Hrs.	8. Date of Bir	rth	9. Birth	nplace (State or Foreign untry)
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	9	show		10a. State 10b. Count	1	10c. City	y, Town or	Location						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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	4	or 28,	Director	10e. Street and Number				10f. Zip	Code			10g. Citi:	zen of What Co	untry?
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		r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		.S. 13	If Yes, spec	ent of Hispani erry Cuban, Me	xican, Puerto	ecify Yes or N Rican, etc.)		Black, White	
	36	or II	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give	NO		1 ☐ Yes	2⊠No Spe	ecify:			Specify: BLA	ACK
	Ö	within 72 hours atter death with the marylative ene. I han 'natural', or Items 23a or 28a-f show the Modical Exp: in at must be notified at	ed b	15. Decede	nt's Education		16a. De	cedent's Usua	I Occupation			16b. Ki	nd of Business/	Industry
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				19a. Informant's Name/Relation	iship (Type, Print)								r Town, State, 2	
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	ore	of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 Removal from State		cemetery, d	sposition (Nar crematory or c	ther place)	l				
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	Baltimore,	permit. Pages 1 a Department of He Important: If Itam any injury or oths		21. Signature of Fureral Service	Decum			321 S	PHILAI	DELPHIA	BLVD,	ABEF	HOME-HAI	RFORD, P.A. MARYLAND 210 Approximate
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		To the within To the compl	Me	29b. Signature and title of cer	tifier A. Pu	endl	6 n	W 2	9c. License nu	1mber 280	0,	29d. D	ate signed (Moi	ntn, Day, Year)
	3	Y		30. Name and address of pers	son who completed cause of	f death (It	em 23a) (T	ype, Print)	in K	W, A	46	MH	20	78
		Si Regis	tate trar	31. Date filed (Month, Day, Yo		strar's Sig	nature	Sel .			/			

06-0243	32
Wilson,	Charles

Please Type or Print in State of Maryland / Department o Certificate o	of Health and Mental Hy	/giene Reg. No.	2006	12300
irst, Middle,Last)		2. Date of Death	Year	3. Time of Death
ichard Allen Wilson		April 9, 2006	i eai	13:16
t institution, give street and number)	4b. City, Town, or Location of Death	4c.	County of Death	

Physician/
Physician/
Medical Examiner

4a. Facility 1

Funeral Director

Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once,

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

7	1. Decedent's Name	e (First, Middle,	Last)							2. Date of De Month	eath Day	Year		me of Death
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ı			give street and number)		4b. City, Tov		ocation o	f Death		4c.	County of De	ath	
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	Social Security N	lumber 6	5. Sex 7. A	ge (In yrs. last bii	rthday)	If Under Months	1 Year Days	If Unde Hours		8. Date of B	Birth (MM/E		Birthplace Country)	e (State or Foreig
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5	2910 Tei	rry Dri	ve, Apt. A				2120)9			Uni	ted Sta	ates	
<u> </u>	11. Marital Status		12. Was Deceden			as Decedent es, specify (ecify Yes or N	N o- 1	14. Race - Am White, etc		dian, 8lack,
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<u> </u>	3 Widowed	4 Divor	rced If Yes, Give Year or Dates:		1	Yes 2X	No	specify:			\$	Specify. W	nite	
5	15. Decedent's Ed	ducation (Specif	fy only highest grade co	mpleted) 16a. durin		nt's Usual Oc	cupation	n (Give k	ind of w	ork done	16b. Ki	ind of Busines	s/Industr	У
	Elementary/Seco	ondary (0-12)	College (1-4 or	5+)		working life.	DO NO	T use re	tired)		Rac	chuba		
	12				A	Arbori						terpris	ses	
3	17. Father's Name ((First, Middle, L	ast)				18	.Mother	s Name	(First, Middle	, Maiden S	Surname)		
5	Michael 19a Informant's Na			19	b. Mailin	g Address	(Street a			asker ural Route N	umber, Cit	y or Town, Sta	ate, Zip C	Code)
-	Tonn	ifor 7al	her - Wife		2910	Terry	Dri	ive .	Apt.	A. Pi	kesv	ille, N	راب 2 ا	1209
	20a. Method of Disp	position	page 19	20b. Place	of Dispos	ition (Name			1	Date		ocation - City		
		X Cremation		west					۸	10 0	006	0.1		
	21. Signature of For	Other Spe		0		natory Name and Ac						Odento l Home,		
	O NII	W O.		1012	/									
-	23a Part I. Enter th	e disease, or co	omplications that caused	the death. Do n	د / ∠ا ot enter t	he mode of o	llIOII lying, su	ich as ca	rdiacor	u., La respiratory a	rrest, shoc	vne, MI		ZZ/ proximate Interval
		ly one cause or				1	-						8ei	tween Onset and Death
	Immediate Cause (or condition resulting		a. Ethanol at		.c use	with c	OMDT:	ıcatı	ons					
	Sequentially list cor	nditions	b.											
2	if any, leading to im cause. Enter Unde	nmediate	Due to (or as a cons	sequence of):										
	(Disease or injury the	hat initiated	c. Due to (or as a cons	sequence of):										
1	events resulting in	dealii) Lasi	d.											
3	XUNPENDED		AMENDED ite	em#23a,27,	perME	,g855,5	/12/0)6 TT						
2	IF FEMALE:		23c. If yes, outco								234	Date of delive	Pro (
	23b. Was decedent past 12 months			ine or pregnancy		etal death	3	Ectopic	pregnar	псу		Month	Day	Year
	1 Yes 2 N			t time of death	5 O	her (Specify	·)							
•			0							-				
	Part II. Other signif	ficant condition	ns contributing to dea	th but not resultir	ng in the u	underlying ca	use giv	en in Pa	rt 1.			se contribute		
5										1 Y	es 2	No 3 Pi	obably	4 Unknown
nandino.										24a. Wa auto	s an opsy			findings available tion of cause of
										peri 1 ✓ Yes	formed?	death?		2 No
)	25. Was case referr	red to medical				26	Place of	f Death (Check o		2140		103	2 110
	examiner?	2 No	Hospital: 1 Inpati	ent 2 ER/C	Outpatient			her4		Home 5	Residen	nce 6 🗸 Ott	ner: Scen	e
	27. Manner of Death		28a. Date of Inj	ury 28b.	Time of 1	njury 280	. Injury a	at Work?		28d. Describe	e how injur	y occurred		
	1 X Natural	5 Pendir	(Month, Day,	Year)		1	Ye:	s 2	No					
	2 Accident	Investi	28e Place of I	njury - At home, f	arm, stree	et. factory. of	fice buil	dina. etc		28f. Location	(Street and	d Number or F	Rural Ro	ute Number, City
	3 Suicide 4 Homicide	6 Could determ	not be	,,		.,,				or Town,				
	29a. Certifier	Certifying Phy	rsician: To the best of n	ny knowledae de	ath occur	red at the tir	ne data	and ala	ne and	due to the co	use(s) and	l manner as et	arted	
3	(iner:On the basis of exa	amination and/or										e(s)
	29b. Signature and	title of certifier	and manner stated			29c. L	icense r	number			29d Da	ate signed (A	1onth, Da	ay, Year)
		\cap	. D	00.			D.C.M.					10, 2006		
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DHMH 17 Rev 1/2001 OCMF 10/2003

State

Registrar

31. Date filed (Month, Day, Year) APR 1 9 2006

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State of Maryland / Department of Health and Mental Hygiene		0.00	The man	
Certificate of Death	Reg. No.	2006	123	-
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	F
Physician/	1
Medical Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

	Registrar			Centi	ricate of	Death			g. No. 🚄 🔱	UD	1600
an/ ner	1. Decedent's Name	e (First, Middle, L Do bera		hart	_{on}			2. Date of Death Month April 7, 20	n Day Yea 06		ne of Death 3:42
	4a. Facility Name (in St. Agnes He		give street and number	er)	4	b. City, Town, or l Baltimore Ci			4c. County of Baltimor	of Death re County	
_	5. Social Security N	lumber 6	Sex 7.7	Age (In yrs. last	birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	h (MM/DD/YYYY	() 9. Birthplace	e (State or Foreig
	212-52-	- 0.	M 2 F	56	Yrs.	Months Days			-1949	Country)	yland
	Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wn or Location	on				10d.	Inside City Limits
ř	md.	Bact	more		Car	tonsvil	1/e			1	Yes 2 No
Director	10e. Street and Nur	mber	+ Shine	Driv	ce.	10f. Zip Code	220	10	g. Citizen of Wh	nat Country?	
	715	645			-	Decedent of His	228	acifu Vac os Na	14 Bass	- American In	dian Black
Funeral	11. Marital Status 1 Never Marrie	ed 2 Marr	12. Was Deceder			es, specify Cuban,			White	e, etc.	1-
by F	3 Widowed	4 Divor	ced If Yes, Give Year or Dates:	1972	1	Yes 2 No			Specify:	Whi	
Completed by	15. Decedent's Ed Elementary/Seco	ducation (Specif	y only highest grade of College (1-4 of	completed) 1	6a. Decedent iring	's Usual Occupati vorking life. DO N		ork done	16b. Kind of Bu		У
nple	12th	oridary (O 12)	2 yea			m tech				rporat	in
	17. Father's Name	•	. 1	SR.	, ,		8.Mother's Name	(First, Middle, M)	
To Be	Kichard 19a. Informant's Na		(Type Print)	JK.	19b. Mailing	Address (Stree	Jane t and Number or F	P. Bo Rural Route Num		vn, State, Zip 0	Code)
-	Collean	Wher		ife	4023		K Ra. 4	+1 W!	less, n	nd. 21	1102
	20a. Method of Disp	position Cremation	3 Removal from		ce of Disposi matory or oth	tion (Name of cen		Date UNK	20c. Location		
		Other Spe			etro (remator					o imd.
	21. Signature of Fu	neral Service Li	censee	1		ame and Address					0/1000
	23a. Part I. Enter th	ne disease, or co	omplications that caus	ed the death. D		e mode of dying,					proximate Interva
	ailure. List on	ly one cause or									tween Onset and Death
	Immediate Cause (or condition resulti		Due to (or as a co		lage due	։ ա ւպա	eu alleur ys	A II			
-	Sequentially list co		b. Due to (or as a co	nsequence of):							
Examiner	cause Enter Under	erlying Cause	C.								
Exal	events resulting in		Due to (or as a co	nsequence of):							
n/Medical	X UNPENDED		_	item#2,2	3a,PII,2	7, perME, g	355,5/22/0	5 TT			
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ā	past 12 months		I LIVE DITTI	n t at time of deat	, - <u>-</u>	aldeath 3 (ner (Specify)	Ectopic pregna	ancy	Month	Day	Year
hysi		No 9 Unkn	9 Olikilowi		_			t			
by P	_		ns contributing to de	eath but not res	ulting in the u	nderlying cause g	jiven in Part I.	23e. Did to	bacco use contr 2 No 3		ause of death? 4 Unknown
ted	Cocaine	e use						24a. Was a			findings availabl
Completed by Physici								autop	med?	prior to comple death?	etion of cause of
င်	25. Was case refer	red to medical				26 Place	of Death (Check		2 No 1	✓ Yes	2 No
Be	examiner?		Hospital: 1 Inp	atient 2 🗸 E	R/Outpatient	1	Other Nursir	-	Residence 6	Other:	
٦. ح	1 Yes 27. Manner of Deal	2 No th	28a. Date of (Month, Da		8b. Time of Ir		y at Work?		now injury occur	red	
atio	1 X Natural 2 Accident	5 Pendir	ng	-7		1`	res 2 No				
tific	3 Suicide	6 Could	not be 28e. Place o	f Injury - At hom	e, farm, stree	et, factory, office b	uilding, etc.	28f. Location (S or Town, S	Street and Numb tate)	er or Rural Ro	oute Number, Cit
Š	4 Homicide 29a. Certifier	detern	(5,55)	f my knowled-s	death occur	red at the time of	ate and place, and	due to the caus	se(s) and manne	er as started	
Medical Certification:	(Check only one) 2		iner: On the best o	examination and							se(s)
Σ	29b. Signature and	title of certifier	and manner stat	1		29c. Licens	e number		29d. Date sign	ned (Month, D	Pay, Year)
	lal.	711	10 sA	51		O.C.	M.E.		APILIC	_ 4,	2000
	30. Name and add			of death (Item 2		n Street Balt	imore MD 21	201			
n to	Zabiullah A 31. Date filed (Mon		ssistant Medical	Examiner strar's Signature		n Street, Balt	iniore, MD 21	201			
tate trar		10 10 Year.	2006	ever A		W.					
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DHMH 17 Rev 1/2001 OCME 10/2003

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#1, perMD 8854.4410/06 TT Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death (First, Middle, Last) Montague Walston **Physician** Month WATSON 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner maryland medical Baltmore N/A If Under 1 Year | If Under 24 Hrs. 8. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F Days MARYLAND 220-36-4338 67 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 EDMONDSON AVE. APT 104 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (AVes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☐XNo þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -2^{-} -12-MAIL CARRIER POSTAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN WALSTON PHYLLIS WHITTAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONTAGUE WALSTON (SON) 8425 CHARLTON RD. RANDALLSTOWN, MARYLAND 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 C emation 3 Removal from State permit. Page Department o importent: if any injury or once. GARRISON FOREST VETERANS 3-18-2006 OWINGS MILLS, MD. JONATHAN /D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature of E 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SepSIS 24 hours /Medical Examiner Gangrene rniere's Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hartown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 (PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 16536

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Records, P.O. Division of Vital funeral director, death. after death the within 24 hours

rthan "natural", or itema 23a or 28a-f show the Medical Examiner must be patified at

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Pages 1 and 2 should be fil trent of Health and Mental H tent: if Item 27 is marked otl jury or other treumatic even

physicien and s the burial-transit

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sign 1 be

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

32, Registrar's Signature

lina

ress of person who completed cause of death (Item 23a) (Type OH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar Amend ite u	State of M. #26 Per	aryland / Depa Verb G85 €e	artment of F	lealth and N B eath		giene Rag. Np. 0	16	12303					
100	Physici	an	1. Decedent's Name (First, Middle, La.	•				2. Date of De Month	ath Day	Year	3. Time of Death					
	/Medic		Raymond Edward Ze					April 1			10:55 a ^M					
	Examin	er	4a. Facility Name (If not institution, given 1238 Vogt Ave	e street and number)			r Location of Death	1		ty of Death						
	Funeral	v3× ≠	5. Social Security Number 6. S	ex 7. Ag	ge (In yrs. iast birthday)	Arbutus If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	Balti							
	Director		219-38-5448	IXM 2□F	65 Yrs.	Months Days	Hours Min.	July 25	1940	Mar	nplace (State or Foreign unity) 'Y Land					
	pu k	1	Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d, Inside City Limits					
	Aaryla f eho	ō	MD N/A		Baltimore	oution .					1√2 Yes 2 □ No					
	r 28a-f ehow	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Co	untry?					
	death with the Maryland rms 23a or 28a-f show rittust be notified at	Funeral Director	4341 Eldone Stree	et		21229			U.S.A.							
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.))- 14. Ra Bla	ice - Amer	ncan Indian, a, etc.					
36	ours after of	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 If Yes, Give 1 Year or Dates:	0/62-	1 □ Yes 2 🖾 No				ity: whi						
00-	"naturel", or ite	ted t	15. Decedent's Ed	Jucation		dent's Usual Occup	ation		16b. Kind of 8	3usiness/l	Industry					
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Maryland 21215-0036	should ind Men in marke	ဥ	19a. Informant's Name/Relationship (Tvoe. Print)	19b. Maili	ng Address (Street				State Z	(in Cade)					
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imo	Pages Tient of ent: If I							5-2006	Elkridg	e, M	D					
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Division of Vital Records,	Phys or this aral di	٦. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier		7	ome 50 hesi 28d. Describe	dence CCO how injury occu	her (Spec irred	residence					
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	4+1		30. Name and address of person who			- 1	himore m	10 2/2×	R							
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Sandro Zurita-Escobar

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State of Maryland / Department of Health and Mental Hygiene

Sandro Zuma-Esc		I- For State Registrar	ile o	i iviai yiailu <i>i</i>		ificate of		iu ivieni	arriygi		g No.	20116	12301
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Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	st birthday)	If Under 1 Ye			Date of Birth	h(MM/DD)/YYYY) 9 Bin Foreig	thplace (State or
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ours a	힑	15. Decedent's Education (Speci	fy only			16a. Decedent	s Usual Occup			done	16b. Kin	d of Business/I	ndustry
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5-0036 ed within 7/ dygiene. other than	탉	10 17. Father's Name (First, Middle, L	ast)			Tile I	nstall		s Name (Fir	st, Middle, M		nstruct mame)	1011
21215-0036 Judd be filed within 7 Mental Hygiene han uarked other than e event, the Medica	8	Francisco Zuri	ta							scobar			
21 21 should also may be assisted by a strice or]≏	19a Informant's Name/Relationshi				1	,					or Town, State	
, MC and 2 s ealth a ealth a	ŀ	Omar Zurita (20a Method of Disposition	Bro	ther)	20b. PI	lace of Disposi			Da			cation - City or	A 22204 Town, State
nore ages 1 at of H t: If it		1 X Burial 2 Cremation		Removal from Sta	ie.	ematory or oth		Parke	4/25	/06	Rore	771 t A 011	i,Argentina
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is warked other tingury or other traumatic event, the Medigury.	-	Donation 5 Other Special Signature of Funeral Service L		ee	1141	22. N	ame and Addre	ss of Facility	,		DCI	Zacegu	1,AIgentina
ii ii ji		Dennis Fir	tn	cem		74		Highw	ay, F	alls (ch, VA	
Physician /Medical		23a. Part I Enter the disease, or c failure. List only one cause of	n eacl	n line.	the death. I	Do not enter th	e mode of dying	g, such as ca	ardiac or res	spiratory arre	st, shock	, or heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	_	lultiple Injuries ue to (or as a conse	quence of)	:							Death
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760, icate be physici the buri	Medical	IF FEMALE:	_	#II. perIn 23c. If yes, outcon		5, 1/31/(ancy	<u> 18 TT</u>				23d [Date of delivery	
ox 687 cath certific	sician/	23b Was decedent pregnant in the past 12 months?		1 Live birth 4 Pregnant at	time of dea	th =		Ectopic	pregnancy		M	onth [Day Year
aw requires that the death certifians been signed by the attending 2 should be detached for use as	ysic	1 Yes 2 No 9 Unkr	nown	9 Unknown		5 Oth	er (Specify)						
bhat the ed by t	by Phys	Part II. Other significant condition	ons c	ontributing to death	but not res	sulting in the ui	nderlying cause	given in Pa	rt I				the cause of death?
S, P.C						<u>.</u>			_	1 Yes			topsy findings available
cords law requi	Completed							-	,	autops perforr	y		completion of cause of
tal Rection: The certificate ector, page	5	25. Was case referred to medical					26 Plea	ce of Death ((Chaoli only	1 Yes 2	No	1 🗸 Ye	es 2 No
Vital hysician this certical	o Be	examiner? 1 ✓ Yes 2 No	Но	spital: 1 Inpatie	nt 2 🗸 E	ER/Outpatient		Other ₄	Nursing Ho		Residence	e 6 Other	
n of \limp Phy	- 1	27 Manner of Death		28a. Date of Inju	ry ear)	28b. Time of Ir	jury 28c. In	jury at Work		Describe h		occurred	
ion ttendi death ttor: / the fi	atio	Natural 5 Pendii 2 Accident Invest		Apr 14, 2006		1140 hrs	1 🗸	Yes 2	No				
Division of Vital Records, P.O. Box 68 piral or Attending Physician: The law requires that the death certificate death. From Directors: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as a second or the property of the prope	Certification:	3 Suicide 6 Could		28e. Place of In (Specify) Con			t, factory, office	building, etc		or Town, St	ate)	Number or Ru Court, Ellico	ral Route Number, City
hou hou		4 Homicide		1: To the best of m			ed at the time.	date and pla					
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Vinneral Director: After this certificate has been signed by the atter completely filled in by the fameral director, page 2 should be detached for u	Medical	(Cited City)	iner: (On the basis of exar									
F > F 0	Ž	29b Signature and title of certifier	, 1	(^	4.0			nse number				te signed (Moi	nth, Day, Year)
		Maryonte Me	V	rule 1	JV()	22.5	0.0	C.M.E.			April 1	15, 2006	
15		 Name and address of person v Margarita Korell MD. 		istant Medical			enn Street, I	Baltimore	, MD 212	201			
Sta	w	31. Date filed (Month, Day, Year)	202	32 Registra	's Signatur	- Josa	20						
Registr	ar	APR 1 9	ZUU	b Flowers	A Miles	A STATE OF THE PARTY OF THE PAR	10)			_			

Certificate of Death

Adams

William

For State Registrar

The law requires that the death certificate be executed Box 68760. Records, P.O. Division of Vital or Attending Physician:

2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** April 2348 Adams, 2006 William Edward Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Easton Talbot Memorial Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**M 2□F Yrs. 213-42-0156 65 Maryland 02 - 10 - 1941Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Cordova Maryland Talbot 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21625 USA 32387 Geib Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 M Married 1 Yes 2 No Specify: Specify Be Completed by 3 Widowed 4 Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than ' ary or other trsumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 9 Utility Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Edward Adams, Sr. Virginia Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32387 Geib Road, Cordova, Maryland 21625 Arnita Adams / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if sny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 04-06-2006 Hillsboro, Maryland Sandtown 22. Name and Address of Facility
Bennie Smith Funeral Home
426 Dover Street, Easton, Maryland 21601 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) 14210 d **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien end the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical use as *IF FEMALE:* 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ H 500C certificate 2 2 10 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Impatient ၉ 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier ARNI 00053110 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Dennis DeShields M.D., 219 so. Washington Street, Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Ma	-	epartmei De <i>rtifica</i>				Re	g. No.)	12306
Discosio		1. Decedent's Name (First, Middle, Last)							. Date of Death Month	Day Y	'ear	3. Time of Death
Physic /Medi		3	erman						March 3	31, 2006		6:08 P M
Exami		4a. Facility Name (If not institution, give					Location of	Death		4c. County of		
		Shady Grove Advent				ockvi er 1 Year		4 Hrs I o	. Date of Birth			tgomery place (State or Foreign
Funeral Director		229-32-9050	7. Age	(In yrs. last birtho	Months		Hours	Min.	(Month, Day, Oct. 14,	Year)	Coul	irginia
and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	10d. Inside City Limits
Maryl i ehc	ŏ	Maryland Montgomer	cy	Gaithe	ersburg	3						1 ☐ Yes 2X No
with the	Direc	10e. Street and Number 9713 Inaugural Wa	ay		10f. Z	ip Code 208	86		10	g. Citizen of Wh	at Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exacuting rougher protified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates:			edent of H ecify Cuba 23 No	ispanic Orig in, Mexican, Specify:	in? (Speci , Puerto Ri	ify Yes or No- can, etc.)		White,	
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nd 2 should be a strong that and he are traumant traumant.		19a. Informant's Name/Relationship (Ty Deborah Spadaro)								City or Town, S		o <i>Code)</i> up, WA 9837
ages 1 a int of Hear r: if item y or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of D cemetery, Metropol	crematory or	other plac	1 4	Dai April 200	5.	oc. Location - C		own, State Virginia
Department of mportant: If it in your or o		21. Signature of Funeral Service Licens			Franc.	ng Addre	ss et 53°11'	ins F	uneral	Home In	C	, MD 20901
ate be executed which in the buriel-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pneumoni Due to (or as a):	ode of dyin	g, such as o	cardiac or	respiratory arre	ist,		Approximate Interval Between Onset and Death 3 Weeks
ath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	2 ☐ Fetal death	3 □Ectopic 5 □ Other (Unio—sopra		23d. Date Mont		ery Day Year
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The late has page 2	Completed									pr ned? de P No 1 (or to coath?	opsy findings available ompletion of cause of
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ding I After tuner	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Inj	ury M	28c. Injur Wor	k? Yes 2∐1	No				
or Attending selected the selection of t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farr . (Specify)	n, street, facto	ory, office		28	3f. Location (St. City or Town		or Rur	al Route Number,
To the Hospital within 24 hours e To the Funeral Completely filled	edicai C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best o nar: On the basis of and manner stat	examination and	death occurre for investigation	ed at the tir	me, date and opinion, deat	d place, ar th occurred	nd due to the ca d at the time, da	tuse(s) and man ate and place, ar	ner as	stated. to the cause(s)
To the within 2 To the complet	M	29b. Signature and title of certifier	7 P. K	URUNIU		9c. Licens D461				9d. Date signed April 2		
5		30. Name and address of person who can Ajit Kuruvilla, M. o	ompleted cause of de	eath (Item 23a) (T	ype, Print)	#208	, Rocl	kvill	e, MD 2	20852		
S' Regis	tate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Apres	5)						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Anna Amrein **Physician** Abrams 2:15 A M Apyll 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Garden at Riderwood Village Silver Spring Montgomery 8. Date of Birth (Month, Day, Ye If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Year) 1908 **Funeral** 1□M 21 F Months 218-50-5455 97 **Director** Washington, Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. Count 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be motified at once. 1 ☐ Yes 2X☐ No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 12729 Eldrid Place 20904 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. ☐Yes 2X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No SpecifWhite Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Amrein Sarah Fitch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martin A. Abrams/ Son 2210 Falling Creek Road, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 1

Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Brentwood, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee Benja 2 Sil MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 days disease or condition resulting in death) /Medical Examiner Sequentially list conditions Due to (or as a consequipe Examine If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events as the burial-transit COPD The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physician ian/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year jo 5 ☐ Other (specify) 4☐Pregnant at time of death Physici P.O. 9□ Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 99 1 Tes 2 No 3 Probably 4 Johnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 No 2 No 1 Tyes 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4☐Nursing Home 5☐ Residence 6 ☐Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No М 2 Accident investigation 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D59524 Whumang MD Loveen 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 GRACEFIELD ROAD SILVERSPRING, MD 2090L LOVEEN J. PUTHUMANA 32 Registrar's Signature State 05 2006 - auce Registrar

		-	State of Maryla		ortment of Health and tificate of Death	Mental Hygie	2000 12000
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) REGINA, LEIGH, ARBAUG	-14		2. Date of Death Month	Day Year 3. Time of Death 2006 8, 52 A M
	Examin	er	4a. Fecility Name (If not institution, give street and number) UNION HOSPITAL		4b. City, Town, or Location of De ELKTON		4c. County of Death CECIL
	Funeral Director			yrs. last birthday) Yrs.	Months Days Hours M	in. (Month, Day, Yo	ear) 9. Birthplace (State or Foreign Country) 16,1966 Mary Land
	Maryland -f show	tor	10a. State 10b. County 10c.	. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 No
	th the	Director	10e. Street and Number	, , , , , , , , ,	10f. Zip Code	10g	. Citizen of What Country?
	s 23a		221 Peppermint Drive 11 Marital Status 12. Was Decedent Ever i	in II 6 12 1	21904	(Specify Vos or No-	USA 14. Race - American Indian,
220	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene Hylgiene dothar than "natural", or items 23a or 28a-f show avant, Ite Modical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever I Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu I ☐ Yes 2🂢 No Specify:	erto Rican, etc.)	Black, White, etc. Specify: White
3-003e	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of	working 16	b. Kind of Business/Industry
7	within ane. than "	Completed	Elementary/Secondary (0·12) College (1·4or 5+)	Nwr	OO NOT use retired)		Health Care
<u> </u>	illed Hygi othar ant, I	a	17. Father's Name (First, Middle, Last)	Nat		Name (First, Middle, Ma.	
yiand	2 should be and Mental is marked c	To B	James <u>Hammer</u>			rooks	
Mar	d 2 should and 7 is m traum		19a. Informant's Name/Relationship (Type, Print) Ann Hammer/ mother		ng Address (Street and Number or Peppermint Dri		
<u>6</u>	s 1 and f Healt Itam 2 othar		20a. Method of Disposition 20		sition (Name of	Date 20	c. Location - City or Town, State
Ē	Page:		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	Calvary	Baptist Church	05-2006 Cemetery	Rising Sun, MD
Baitimore	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or othar traumatic av once.		21. Signature of Funeral Service Licensee	22 11	Name and Address of Facility 1 S. Queen St.,	R.T. Foard	Funeral Home, P.A.
H			23a. Palt 1. Enter the disease, or complications that caused the canadak, or heart failure. List only one cause on each line.	4		diac or respiratory arrest	Approximate Interval Between Onset and Death
	Pnysician /Medical		resulting in death)	RENAL	FAILURE		
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	p #	ner	if any, leading to immediate Due to (or as a con-	isequence of).			
Ď,	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a con		PNEUMONIA		
68/60	icate be ex physician s the buria	dical	d				
. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ds, P.O	ires tha signed d be de	by	Part II. Other significent conditions contributing to death but not	t resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
Record	law requas been 2 should	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
							d? death?
Z Z	Physiclan: r this certificatal director, i	o Be	25. Was case referred to edical examiner? 1 — Yes 2 — No Hospital: 1 — Impatient	2 ER/Outpatier	Other	Death (Check only one)	ce 6 □Other (Specify)
Division of Vital	ding Phy h. After this funeral c	<u>-</u>	27. Manne Death 1 atural 5 Pending (Month, Day Yea 2 Accident investigation	28b. Time o		28d. Describe how	
Divis	5 t t o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (See		reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or A within 24 hours after To tha Funaral Dirac completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my and manner stated.	/ knowledge, deat mination and/or in	h occurred at the time, date and p vestigation, in my opinion, death o	occurred at the time, date	a and place, and due to the cause(s)
ì	To II withi To II	Σ	29b. Signature and title of certification and ti	MD	29c. License number D 006346		1. Date signed (Month, Day, Year) PIL, 2, 2006
	2		30. Name and address of person who completed cause of death 106 Bow Sa	treet, El		•	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 5 2006 Security St	Signature			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Рм Mary Katherine Adorney 2006 March 30 3:49 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Hospice House Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🖫 F 035-40-7707 50 Director Dec. 8, 1955 Rhode Island Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar numbs be notified at Maryland Talbot 1 ☐ Yes 2 No Easton Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9250 Rockcliff Drive 21601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXVo White Specify: <u>م</u> 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Claims Examiner 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be inent of Health and Mental but: if item 27 is marked of Frank Adorney, Sr. Edna Daubert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Adorney, Sr./father 9250 Rockcliff Drive Easton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of importent: if any injury or once. 4 □ Donation 5 □ Other (Specify) Lakemont Mem. Gardens 4/4/2006 Davidsonville, MD ce Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death Immediate Cause (Final **Physician** gvaria months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2/1 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an has autopsy performed? 22 No 1 Yes Be 25. Was case referred to medical examiner? Hospice House 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence SYXOther (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or All within 24 hours after of to the Funeral Directions 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 01, Mary 25/11/21 Easton 2160 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State 3 2006 Registrar

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		•	For State Registrar	State of Marylar	Certificate of Death	Reg. N	THE LOCKE
3	Physicia	an	Decedent's Name (First, Middle,	Last)	2 1 -	2. Date of Death Month D	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution,	riva straet and number)	4b_City, Town, or Location of	3 2 Death 4	C. County of Death
	Examin	er	151 50 11	svilla Rd	CONTRIVIL	10	DULLEN AMPES
	Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. 12 M 2 ☐ F	Months Davs Hours	8. Date of Birth Min. 3/12/19	9. Birthplace (State or Foreign Country)
in the	Director		Usual Residence of Decedent	×M 2□F 59	Yrs.	3/12/19	141 Marylana
	nyland how		10a. State 10b. County	Λ 10c. Cit	ty, Town or Location		10d. Inside City Limits
	he Ma	Director	MD queer	v knnes c	ENTROVIIIQ 101. Zip Code	100.0	1 ☐ Yes 2 No itizen of What Country?
	after death with the Marylan or items 23a or 28a-f show out at most be rollited at	i Dir	10e. Street and Number	isvilla Pd	21/1/1	11	SA
	ems 2	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Was Decedent of Hispanic Original II Yes, specify Cuban, Mexican	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s after	by Fu	1 Never Married 2 Marrie		1 ☐ Yes 2 No Specify:		Specify: Black
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or items 23a or 28a-f show ta Madical Examinar must be notified at	ted t	15. Decedent's	Education	16a. Decedent's Usual Occupation	of working	Kind of Business/Industry
121	vithin 7	Completed	(Specify only highest Elementary/Secondary)(0.12)	College (1-4or 5+)	(Give kind of work done during most life. DO NOT use retired)	cheo; s	of Complained
	il Hygiene.		17. Father's Name (First, Middle, La	ast)	18. Mothe	r's Name (First, Middle, Maide	on Sumame)
Maryland	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 ie marked other than "netun other traumatic event, ille Medical	To Be	William	NENRY BOX		A Elimaba	THE MORRIS
Man	12 sho h and 7 le mu traum		19a. Informant's Name/Relations i	р (Туре, Print)	19b. Mailing Address (Street and Number	r or Rural Route Number, City	or Town State, Zip Code)
	s 1 and 2 f Health item 27 other tr		20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - city or Town, State
mo	0 = 5		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State). Voteran Comoterio	3 31 06 1	urlock MD
Baltimore,	permit. Pages Department of Important: If i Iny injury or one		21. Signature of Funeral Service Li	селье	22. Name and Address of Fallit	19 11 /01/01	NIX
.0	40.204		23a. Part1 Enter the disease, or c	omplications that caused the dea	th. Do not enter the mode of dying, such as	cardiac or respiratory arrest,	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line.			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec			
Н	LXammer	- G	Sequentially list conditions,	bbue to (or as a consec	quarica of):		
	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.			
,092	be executed siclen and burial-fransit		resulting in death) Last	Due to (or as a consec	quence of):		
6876	leath certificate b attending physic I for use as the b	dical		d			
Box (n certif	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta			23d. Date of delivery
). B	e deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of o			Month Day Year
P.0	res that the de igned by the a be deteched f	, Ph		s contributing to death but not re-	sulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	w requires been sign should be	ed by	COPD			1 ☐ Yes	2 DNo 3 Probably 4 □Unknown
eco	taw rees bee	Completed	XX			24a. Was an autopsy	24b. Were autopsy lindings available prior to completion of cause of
E R	sician: The law certificate hes t irector, page 2 s					performed? 1 ☐ Yes 2 ☑	death? 1 Yes 2 No
Vita	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2		of Death (Check only one) rsing Home 5 ☐ Residence	6 □Other (Specify)
Division of	ding Phys .r After this funeral di	n: To	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury	28b. Time of Injury at Work?	28d. Describe how in	
sior	tendir Jeath. tor: Af the fur	catic	2 Accident investiga 3 Suicide 6 Could no	tion	M 1 Yes 2 1		and Number or Rural Route Number,
Divi	after after Direction by	Certification:	4 ☐ Homicide determin	building, etc. (Speci	nome, farm, street, factory, office (fy)	City or Town, Sta	
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	calC	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my kn	owledge, death occurred at the time, date an ation and/or investigation, in my opinion, deat	d place, and due to the cause	(s) and manner as stated.
	the H thin 24 the F mplete	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	N T S		. 7 11	mula_MD	D-029.		1ch 28, 2006
			30. Name and address of person w	no completed cause of death (Ite	m 23a) (Type, Print)	1	•
			31. Date filed (Month, Day, Year)	Corman Con N	¹^ D.		
	Sta Regist		MAR 2	8 2004 Malie	& Sperti		

			For State	State o	of Marylar				d Mental Hy	giene	10011
_			1 Stete Registrar 1. Decedent's Name (First, Middle	o 1 201)		Cei	rtificate of	Death		Reg. No. UUO	14311
1	Physici		ROSEMARY	AMELIA	Б	BLEDSOE			2. Date of Dea	Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution			PEDSOE	4b. City, Town, or	Location of De	64 ⁻	4c. County of Dea	
			SHADY GROVE AD	VENTIST H	OSPITAL		ROCKV1	LLE		MONTGOME	RY
	Funeral Director		5. Social Security Number 577 18 0752	6. Sex 1 □ M 2 2 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	Irs. 8. Date of Birt (Month, Day FEB . 24	y, Year) 9. Bii 1914 INC	rthplace (State or Foreign ountry) OIANA
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Mary	tor	MD. MONTO	OMERY	(GAITHER	SBURG				1 XYes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a	rai	407 RUSSELL AV				20877			UNITED STA	
21215-0036	d within 72 hours after death with the Maryland jene. rr then "natural", or items 23a or 28e-f ehow the Medical Examiner must be notitied at	by Funeral	11. Marital Status 1 Never Married 2 Marriad 3 Widowed 4 Divorced	ied Armed Fo	2 ⊠No ve		Was Decedent of H f Yes, specify Cuba 1 □ Yes 2⊠ No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: WHI	te, etc.
5-0	72 ho natur	eted	15. Deceden	t's Education st grade completed)		16a. Deced	lent's Usual Occup	ation	working	16b. Kind of Business	
121	within the	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)	working		CAMENT
9	Hygir Hygir Ther		17. Father's Name (First, Middle,	Last)		ADMIN	ISTRATOR	18. Mother's N	Name (First, Middle,	U. S. GOVE	RNMENI
an	Jid be Jentai rked c	To Be	DOLPHUS BLEDS	0E				JANI		_ EPRIVA	
Maryland	2 sho and h is ma auma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Numbe	r, City or Town, State,	Zip Code)
	1 end dealth em 27 ther to		CHRISTOPHER ALL 20a. Method of Disposition	EN, PERS.		4 Pr	ofessiona sition (Name of	1 Drive	#140,Gai	thersburg, 20c. Location - City or	Md.20879
nor	ages ont of tr. if its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	cemetery, cren	k Cemeter	9)		Gaithersbur	
Baltimore,	permit. Pages 1 end 2 should be Deperment of Health and Mental Important: if Item 27 is marked eny injury or other traumatic events.		21. Signature of Funeral Service	Licensee		22			FUNERAL H		g, Mu.
ä	Depermiting Depending Important Important Irraportant		Muriel	N. 13a	relier	T T			FUNERAL F AYTONSVILL		
,	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	caused the deal each line.	th. Do not ent	er the mode of dyin	g, such as card	liac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Examiner		Sequentially list conditions,	h	(0) 40 4 00/1500	(durios or).					
	sit s	iner	cause. Enter Underlying Cause (Disease or injury	Die to	(ur as a consec	(to soneu):					
_	cate be executed physicien and the burial-transit	Examin	that initiated events resulting in death) Last	c	(or as a consec	quence of):				-	
38760,	ysicier e buri	dicai		d							
•			IF FEMALE:								
P.O. Box	the death certific by the ettending parched for use as	Physician/M	23b. Was decedent pregnant in the past 2 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	1 ☐Live b	tcome of pregna pirth 2 Teta nant at time of c own	aldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	law requires thet the de as been signed by the e 2 should be detached fo	þ	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute to es 2 No 3 P	the cause of death?
Il Records,	The ate h page	Completed						-	24a. Was a autob perior	sy prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			2 DOA Othe		eath Check only or	ne/	
ð	Phys er this eral di	n: To	1 ☐ Yes 2 ☑ No 27. Vanner of Death	28a. Date	of Injury	ER/Outpatien 28b. Time of	28c. Injury Work	4 Nursing		ence 6 Other (Spe	ecify)
ion	Attending in death.	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	th, Day Year)	Injury		k? Yes 2∐No			
Division of Vital	₽ 1	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Place	of Injury - At hing, etc. (Special	ome, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number.
	the Hospital iin 24 hours of the Funeral ipletely filled	ledical	one)	and man	a best of my kno asis of examina ner stated.	owledge, death ation and/or inv	occurred at the time time of the time of time of time of the time of t	ne, date and pla pinion, death oc	ice, and due to the c courred at the time, d	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
)	To Tool	Σ	29b. Signature and title of certifie	MD			29c. License	number 263	4	29d. Date signed (Mont	th, Day, Year)
	<i>V</i>		30. Name and address of person Hakim MDRS	41 9901	Medi	т 23a) (Туре, СС С	enter D	rive R	ockville,	4/3/20 MD Z	0850
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5	2006 32 R	legistrar's Signa	ture Ass	de				

State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND#17perFH4/6/06, BMW, MoCoCertificate of Death Rea No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Harriet P. Best March 28, 2006 12:27P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Health & Rehab Center Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 3, 19 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🏝 F 057-20-4617 79 1926 New York Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylau Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other treumetic event, If a marked other treumetic event, If a marked other treumetic event, If a marked other treumetic event, If a marked other treumetic event, If a marked other treumetic event, If a marked other treumetic event, If a marked event event event event. 1XXYes 2 □ No Director Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 U.S.A. 3200 N.Leisure World Blvd # 201 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Dental 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First Middle, Last)
Abraham Polsicy Be Alpert Esther 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 399 Madison Ave. Glencoe III. 60022 19a. Informant's Name/Relationship (Type, Print) Rachel Ferber-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition (injury or 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 3-30-06 Judean Mem. Garden Olney, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityEdward Sagel Funeral Direction 21/Signatu f Euneral S 1091 Rockville Pike Rockville, MD 20852 Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months Pnysician Sarcoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it july) that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 🗆 No 1⊟ Yes 2X No 1 Yes To the Hospitel or Attending Physicien: after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No 2 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 1 X Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-30-06 D0053615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Arupa Nathan, MD 1125 Rockville Pike # 208 Rockville, MD 20850 Aruna Nathan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 05 2005 Cally Car Registrar

Physician: The law requires that the death certificate be executed P.0. of Vital Records, has this After

Amend item#23a,27,28a-f, penME e855,5/1/2006 TT of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Norbert Bender M MARCH 31 2006 3:01P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY Hours Min. 8. Date of Birth (Month, Day, Ye 3 – 24 – 1926 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) New York 1**₺** M 2□ F 578-40-8037 80 Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Montgomery Silver Spring 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14809 Pennfield Circle #411 20906 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? LEWes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: WWII Specify: Specify:White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer NASA 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Lillie Leo Bender Brott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14809 Pennfield Circle # 411 Silver Spring, MD 20906 Mildred Bender -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Judean Mem. Garden 4-2-2006 Olney, MD 21. Signature of Funera Service Licensee 22. Demaransky of Goodsdberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20352 M 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive atheresclerotic cardiovascular disease disease or condition resulting in death)

List only one cause on each line. Hypertensive atheresclerotic cardiovascular disease disease or condition resulting in death)

List only one cause on each line. Hypertensive atheresclerotic cardiovascular disease or condition resulting in death) Approximate Interval Between Onset and Death /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physicien end the burial-transit Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 99 as been signal 3 Probably 4 □Unknown Be Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy performed? page 1 X Yes 2□No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 🗆 No Certification: To 2 XER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 X Accident 3 Suicide wheelchair 5 Pending stopped abruptly and deeth. investigation 3/31/2006 2:40 P 1 ☐ Yes 2√√XNo after deeth the subject was ejected 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 14809 Penfield Circle filled in by 28f 4 Homicide within 24 hours a To the Funeral C field next to residence Silver Spring, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. APRIL 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 -12 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 2006 5 Registrar

		1	For State Registrar		State of	f Marylar		artmen rtificat					eg. No.	nna	123	encomp.
	Division	_	1. Decedent's Name (First,	Middle, Last)								Date of Dear Month	th Day		3. Time of	of Death
	Physicia /Medic	al	SANDRO	ARMAN		BARONE						March 3			5:50	A M
7	Examin		4a. Facility Name (If not inst							Location of				County of Dea		
			8103 Easte			313 7. Age (In yrs.	last hirthday		er S	pring If Under		8. Date of Birth		ontgome		or Foreign
	Funeral Director		5. Social Security Number 073-12-0265		M 2□F	7. Age (III yrs.	84 Yrs.	Months	Days	Hours	Min.	02 - 11	Year)	922	thplace (State ountry) Oh	io
	and w	-	Usual Residence of Deceder 10a. State 10b. C			10c. Ci	ty, Town or L	ocation				-			10d. Inside (City Limits
	Maryl f sho	ō	Maryland Mon	tgome	ry	Si1	ver Sp	ring							1 ☐ Ye	s 2 🕅 No
	the r 28a	rec	10e. Street and Number					10f. Zip	Code			1	0g. Citi	izen of What C	ountry?	
	h with	al D	8103 Eastern	Avenu	e, #3	13		20	0910				U	J.S.A.		
G	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "natural", or items 23a or 28a-f show event, the Madral Examinar must be notified at	Funeral Director	11. Marital Status 1 ☐ Never Married 25		Armed Fo	2 🗆 No		Was Deced If Yes, spec				ecify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	te, etc.	
<u>8</u>	ral', c	d b	3 ☐ Widowed 4 ☐ Div	besno	Year or D	ates:Kore	a									
21215-0036	72 h	Completed	15. De (Specify only	cedent's Educ highest grade			16a. Dece	dent's Usua kind of wo DO NOT u	rk done	ation during mos	it of work	ing	16b. Ki	ind of Business	/Industry	
121	within 100.	d m	Elementary/Secondary (0	-12)	College (1			COLO		,			ΙT	S.ARMY		
7			17. Father's Name (First, M	iddle, Last)		<u> </u>	1 1.1	COLO	VEL	18. Mothe	er's Name	(First, Middle,				
an	should be filed nd Mental Hygi marked other imatic event, I	To Be	Nicola Baron	е						Carm	e1a	Costanza	a			
Maryland	shour nd M mar	-	19a. Informant's Name/Rel	ationship (Ty	oe, Print)		19b. Mail	ing Address	(Street	and Numb	er or Run	al Route Number	r, City o	or Town, State,	Zip Code)	
ž	alth a		Soledad I. B	arone	(Wife)		8103	East	ern .	Ave.,		3, Silve	er S	Spring,	MD. 20	910
Je,	item of He Officement		20a. Method of Disposition	-tion 2 🗆 🗆	omovel from	State	Place of Disp cemetery, cre	matory or c	ther plac				20c. Lo	ocation - City or	Town, State	
E	Page His Rep		17∰Burial 2 ☐ Crem `4 ☐ Donation 5 ☐ Ot		emovai irom	Ar1	ington N	Nationa	1 Cem	etery	5/18	/06	Ar1	ington, V	Jirginia	
Baltimore,	perrii. Pages 1 and 2 should be Departiment of Health and Menta Importentie. If item 27 is marked any injury or other traumatic wonce		21. Signature of Funeral S	ervice License	97	V.						phy Fall t, Falls				
			23a. Part 1. Enter the disea shock, or heart failure	se, or compli	cations that o	aused the dea	th. Do not er	iter the mod	de of dyin	g, such as	cardiac	or respiratory arr	est,		Approxima Interval Bo	etween
J.	Physician		Immediate Cause (Final disease or condition	. 2.01 01119 01		ere Ao	rtic S	tenos	is						1997	d Death
7	/Medical		resulting in death)			(or as a conse		cenob.							1990'	s
	Examiner		Sequentially list conditions)	ere Re		ive L	ung]	Disea	se				10 yr	
	p =	iner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury			(or as a conse		11 0-		- C -	1- D	1 - 1 1			2/2005	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			nsition		II Cai	icer	OI L	ne B	ladder			2/2005)
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687	cate physi	dicai			1											
9 ×	eath certificate be executed attending physician and for use as the burial-transit	/Me	IF FEMALE:	2		tcome of pregn								23d. Date of de	elivery	
Вох	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Med	23b. Was decedent pregnation the past 12 months 1 □ Yes 2 □ No		4☐Pregr	oirth 2 Fet nant at time of		□Ectopic p □ Other (s _i		<u>'</u>				Month	Day	Year
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Records, P.	requires that the death een signed by the atte hould be detached for	þ	Part II. Other significant c	onditions cor	tributing to d	eath but not re	sulting in the	underlying (cause giv	en in Part	l.		bacco i	use contribute t	_	f death?]Unknown
202		Completed										24a. Was a		24b. Were a	utopsy finding	s available
Re	The law ate has b page 2 st	ш										autop perfor 1 Yes	med?	death?	completion of s 2 No	cause or
Vital	ilcien: Th certificate rector, pag		25. Was case referred to r	nedical						26. Plac	e of Deat	h (Check only or	2 x No ne)	, , , , ,	3 20110	
>	Physicien: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🕱 No	_	lospital:	Inpatient 2	☐ ER/Outpatie	ent 3 D	OA Oth	ler: 4 □ N	ursing Ho	me 5 Resid	ence	6 ☐Other (Sp.	ecify)	
on of	fe fe			Pending investigation	28a. Date (Mor	of Injury eth, Day Year)	28b. Time Injury	of M	28c. Injur Wor 1 🗀	yat k? Yes 2 ⊑]No	28d. Describe h	ow inju	ry occurred		
Division	l or Attending after death. Director: After I in by the fune	Certification:		Could not be determined		e of Injury - At I ling, etc. (Spec		treet, factor	y, office			28f. Location (S City or Tow			Rural Route Nu	ımber,
_	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier 1 ☑ C (Check only 2 ☐ M	ertifying Phy edical Exemi	ner: On the b	e best of my kn pasis of examin	nowledge, dea nation and/or i	ath occurred investigation	at the tire, in my o	ne, date a pinion, de	nd place, ath occur	and due to the or	ause(s date and) and manner a d place, and du	is stated. le to the cause	e(s)
	To the vithin To the comple	Me	29b. Signature and title of	certifier	81	1				e number		2	29d. Da	ate signed (Mor	ith, Day, Year)	
	F > F 0		1 Nous	all	1th	Y		1	000	53	94	3	4	45 n	6	
	12		30. Name and address of	person who co	ompleted cau	se of death (Ite	em 23a) (Type	e, Print)		1		, ,		3 10	4	\
			Susan	Bri	insl	II N	NMC	84	011	WISC	ons	in Ave	- 1	Sethe	sdan	1D
	St Regist	ate rar	31. Date filed (Month, Day	Year) 0 5 20	06 32	Registrar's Sign	nature	serle	,						209	384

	1 - For State Regist			State of	Marylar	nd / Depa <i>Cei</i>		te of E			F	Reg. No.	U 6	12315
Physician /Medical Examiner	WALT	's Name (First, MER RAE I	BOONE	reet and numb	er)		4b. City	, Town, or	Location of	1	Date of Dea Month	Day	Year	3. Time of Death
Funeral Director		curity Number 66-4032	6. Sex	7. v 2 F	Age (In yrs.	last birthday) Yrs.	If Under	or 1 Year Days	If Under 2 Hours		Date of Birth Day	1938	9. Birth	place (State or Foreig
Maryland a-f show illies at	10a. State	lence of Deceden			10c. Ci	ty, Town or Lo								10d. Inside City Limit
hours after death with the Maryland tural; or items 23e or 28e-f show al Examiner must be notified at ed by Funeral Director	10e. Street 2951	and Number 3 NANCY		r 2. Was Decede	ent Ever in I	S 13 1			L601	in? (Specif	fy Yes or No-	10g. Citizen	of What Cou USA Race - Ameri	
be lieu within 72 mous and locall will the wayyan latel Wighten. Ital Mygine. event, the Mydical Examinar must be notified at event, the Mydical Examinar must be notified at Be Completed by Funeral Director	3 □ Wid	er Married 2 X owed 4 □ Divo	Married	Armed Force 1 Yes 2 If Yes, Give Year or Date	es? I X No		fYes, sp 1 ☐ Yes	ecify Cubar 2 Ϫ No	Specify:	Puerto Ri	can, etc.)	Spe	stack, White, cify: WH	etc. L TE
Hygiene. Whygiene. When then "natural and," the wad call a	Elementa	15. Dece (Specify only hi ry/Secondary (0- 12			or 5+)	life.	kind of w	ork done d use retired)	uring most				IL SA	
ind Mental Hygi marked other umatic event, To Be Co	WILI	Name (First, Mid LIAM ALTO ant's Name/Relat	ON BOO			19b Mailir	ng Addres		RUTE	I SWI	First, Middle, FT Route Numbe			o Code)
of Health ar	20a. Method	ORIE J. d of Disposition rial 2 Cremat	BOONE	/WIFE	ate	29513 Place of Dispo	NAN sition (Nanatory or	ICY S'	REET,		TON, M	D 2160		own, State
Department Important: fany injury o	-	re of Funeral Ser		Ostiesa		cco 1	. Name a	nd Addres	s of Facility	NBEIN		NAM FU	NERAL	HOME PA
physicien and physicien and street st	Sequential if any, lead cause. Ent Cause (Dis that initiate resulting in	y list conditions, ing to immediate er Underlying ease or injury	a. b. c. d.	Due to (or	as a consec as a consec as a consec	quence of):		(- ,	\s.v.	(((6	u-t.c			
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been signed by the a should be detached feet by Physic	Part II. Other	or significant cor		- 11	th but not res			cause give				obacco use c		he cause of death?
ate has		se referred to me	ndical						26 Place	of Death (med?	b. Were auto prior to co death? 1 \(\text{Yes}	opsy findings availab impletion of cause o
sid in	examin 1 🗆 Ye	s 2.50 No of Death ural 5.☐ Pe		28a. Date of (Month,		ER/Outpatier 28b. Time o Injury		28c. Injury Work	r: 4 🗆 Nur:	sing Home	5 ☐ Resid	lence 6 🗆		fy)
within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:		micide de	ould not be etermined	building	, etc. (Speci						City or Tou	n, State)		al Route Number,
n 24 hours he Funeral pletely filled	29a. Certifi (Checi	conly 2 Med	lical Examine	cian: To the b er: On the bas and manne	is of examina	owledge, deatl ation and/or in	vestigatio	n, in my op	inion, death	place, an	at the time,	date and plac	e, and due t	stated. o the cause(s)
vithin 2 To the complete		ture and title of ce	ntifier		0	0	2	9c. License		. 1 4				Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	1	For State Registrar			,	Certific	cate of	f Death		Reg. No.	UU6	12	316
Physician	1.	Decedent's Name (First,		1377E	10	onard	BI	Zown	2. Date of De Month	Day	1-200	1 0	me of Death
/Medical Examiner	4a	. Facility Name (If not ins						, or Location of Deat			County of De		, , ,
		Memo	nal	HOS	Spi-	tal	٤	ASTON	7	***	TAI	bot	
neral ector		Social Security Number 15–32–9423	6. Se	X 7. AQ	ge (In yrs. 70		Inder 1 Yearnths Day			Year)	935	lirthplace (S COUNTY) OHIO	tate or Foreigr
)r	-	sual Residence of Deced	ent										
_		Da. State 10b. 0	County		10c. Cit	y, Town or Location	n						ide City Limits]Yes 2 ☐ No
Director	-		TALBOT			EASTO				10° Cit	izen of What		
P	10	De. Street and Number 117 E. DOVE	R ST.	APT 204		10	of. Zip Code 21 6			rug. Cit	US.		
Funeral	1	1. Marital Status		12. Was Decedent		S. 13. Was I		f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No	0-	14. Race - Ar	merican Indi	an,
		1 Never Married 2		Armed Forces? 1 Yes 2 1 If Yes, Give			es XX N		to nicall, etc.;		Black, W.		
yd by		3 ☐ Widowed 4 XDr		Year or Dates:						16h K	ind of Busine	WHITE	
Completed		(Specify only		fe completed)		16a. Decedent's (Give kind life. DO N	of work dor OT use reti	ne during most of wo	rking	100. K	and or busine.	samuusny	
Eo		Elementary/Secondary (0-12)	College (1-4or	5+)	MANAGEMI	ENT CO	ONSULTANT		CON	SULTAT	ION F	ERM
BeC	1	7. Father's Name (First, A	fiddle, Last)						me (First, Middle		Sumame)		
5		CHARLES LE							EL HOFFE				
	1	9a. Informant's Name/Re JENNIFER B			R	-		et and Number or R				_	
	2	Da. Method of Disposition			20b. F	_ lace of Disposition emetery, cremator	(Name of	1/2021	Date	20c. Lo	ocation - City	or Town, St	ate
	i	1 ABurial 2 □ Crem 4 □ Donation 5 □ O			9	KEVIEW C			13/2006	SY	KESVIL	LE, M)
	2	1. Signature of Funeral S				22. Na	me and Add	ress of Facility HELFENBE					
		Joseph ?		trously (200	S. H	ARRISON S'	r easton	, MD	21601		
		23a. Part1. Enter the dise shock, or heart failur	ase, or comp e. List only o	lications that cause one cause on each	ed the deat line.	h. Do not enter the	b to abom e	lying, such as cardia	c or respiratory a	arrest,		Interv	ximate al Between t and Death
	10	mmediate Cause (Final lisease or condition esulting in death)	_	a	Surc	Obstru	CT 14	e pulmon	my de	seas	ie	yeo	·vS
		•		Due to (or as	s a conseq	uence of):		'	9				
ē	ii	equentially list conditions any, leading to immedia	ie)	Due to (or as	s a conseq	uence of):				-			
Examin	t	ause. Enter Underlying Cause (Disease or injury hat initiated events		c									
		esulting in death) Last	8	Due to (or as	s a conseq	uence of):							
Medical				d									
		F FEMALE: 23b. Was decedent pregn	ant	23c. If yes, outcom							23d. Date of	delivery	
icia		in the past 12 month: 1 🗆 Yes 2 😿 No		1□Live birth 4□Pregnant a 9□Unknown			opic pregna er (specify)				Month	Day	Year
Physician/	-	9 Unknown			but not see	ulting in the under		awan in Bort I	23e Did	tobacco	use contribute	a to the caus	se of death?
		Non - Hal	e biss	Lunha	out not res	alling in the under	yng cause	given in raiti.		Yes 2			4 Unknow
etec	-	12 souls	11	(,				24a. Wa:	s an	24h Were	autonsy fin	dinas available
Completed by	1	J J Fen	7100						auto perf	opsy ormed?	death	to completion? 'es 2 □ N	dings available in of cause of
Be		25. Was case referred to	medical					26. Place of De	1 ☐ Yes ath (Check only	2 No) 101	92 Z N	0
ToB		examiner? 1 ☐ Yes 2 🗗 No	1	Hospital: 1 Minpat	tient 2	ER/Outpatient 3	DOA	Cther: 4 ☐ Nursing	Home 5□Res	idence	6 □Other (S	pecify)	
		7. Manner of Death 1 → Natural 5 □	Pending	28a. Date of Inj (Month, D	jury Jay Year)	28b. Time of Injury		njury at Vork?	28d. Describe	how inju	iry occurred		
Cati		2 Accident	investigation Could not be		niunz - A+ h			☐Yes 2☐No	28f. Location	(Street a	nd Number or	Rural Rout	Number
Certification:	3	4 Homicide	determined	building, e	etc. <i>(Speci</i>	ome, farm, street, (y)	iactory, offic	ν σ	City or To	own, State	е)		o . vanibel,
Calcal		29a. Certifier 127 C (Check only 2 N	ertifying Philedical Exam	niner: On the basis	of examina	owledge, death occ ation and/or investi	curred at the gation, in m	e time, date and place by opinion, death occ	e, and due to the urred at the time	e cause(s , date an	and manner d place, and	as stated. due to the ca	ause(s)
Medical Certification: To Be Com		29b. Signature and title f	certifier	and manner s	oidibu.		29c. Lice	ense number		29d. Da	ate signed (M	onth, Day, Y	'ear)
	1	burt	111	an no			03	19749		4/	7/06	•	

30. Name and address a person who completed cause of death (Item 23a) (Type, Print) D. GREG OLIVER M.D. 503 CYNWOOD DR EASTON, MD 21601

31. Date filed (Month, Day, Year)

APR 1 0 2006



State

Registrar

-6

State Registrar

Ling Li, MD Assistant Medical Examiner 111 F
31. Date filed (Month, Day Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

APP

111 Penn Street, Baltimore, MD 21201



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Apri accob 0510 AM **PHYLLIS** OB CATHERINE **BYRD** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛛 F Yrs. 84 220-16-0904 MARYLAND Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ahow is 1 and 2 should be filed within 72 hours after death with the Maryla. of Heelth and Mental Hygiene. It has a state of the marked other then "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinate with be notified at 1 Yes 2 □ No Directo BOONSBORO MARYLAND WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 212 MAPLE AVENUE 21713 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☑ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SECRETARY FEDERAL GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID I. BYRD AMANDA V. BABINGTON Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) W. WAYNE BYRD/BROTHER 13424 CHERRY TREE CIRCLE, HAGERSTOWN, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Importent: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 04/11/2006 ROHRERSVILLE, MARYLAND MT. ZION CEMETERY 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached t ☐Yes 2 ☐No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 1 Yes 2 No 3 Probably Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes t lirector, page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 □/No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after on Funerel Direction Place in Place in Place in Part in 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 2 To the 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D060396 06 04/08 1126 Opal 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIN 5460 NWS FARID SH L 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Depar		_		
		•	FOR	ificate of Death		2006	12319
			Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physicia /Medic		ELMER ELWOOD BERNHISEL		April_	4 2006	8:30pm M
	Examin			4b. City, Town, or Location of Death		4c. County of Death	
			Ravenwood Lutheran Village 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washingt	
	Funeral Director			Months Days Hours Min.	Month, Day, JUNE 28.		nplace (State or Foreign untry) NSYLVANIA
	D.		Usual Residence of Decedent		JOHN 20,	1000 1111	
	arylar show	5	10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits 1 ☑ Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show crimes be recified at	Director	MARYLAND WASHINGTON 10e. Street and Number	hagerstown	10	g. Citizen of What Co	
	with 3a or	直	1100 LUTHER DRIVE	21740		U.S.	
	death ms 2:	Funeral		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Amer Black, White	ican Indian,
9	or Ita		1 □ Never Married 2 □ Married 11 ☑ Yes 2 □ No 1943 − 11 ☐ Yes Give	Yes 2 No Specify:	110411, 01017	Specify:	
Ş	hours tural',	ed by	3 X Widowed 4 Divorced Year or Dates: 1946	ent's Usual Occupation	1	6b. Kind of Business/I	WHITE
7.	in 72 n "nal	plete	(Specify only highest grade completed) (Give ki	ind of work done during most of workir O NOT use retired)		ob. 14114 of 540110041	, audiny
212	filed withi Hygiene. ther than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	SEALER	A	IRCRAFT MA	NUFACTURE
pu	d d d	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		laiden Sumame)	
yla	should be ind Mental marked o umatic eve	ဥ	ALBERT BERNHISEL	I SABELLE Address (Street and Number or Rura		City or Town State 7	in Code)
Mar	d 2 should th and Mer 7 Is marke traumatic						21740
altimore, Maryland 21215-0036	permit. Pages 1 and 2: Department of Health ar Important: If itam 27 Is any injury or other trau		20a. Method of Disposition 20b. Place of Disposi	BEAVER CREEK ROAL		Oc. Location - City or	
E O	Pages nent of I int: If its iry or o		124-bunar 2 Cremation 3 Chemioval non State	N MEM. PARK 04/08	3/2006	HAGERSTOW	N, MARYLAND
alti	permit. Departm Imports any inju		21. Signature of Funeral Servic / Licensee 22.			National	
Ω_	89589	111	au 1/2/10			o, Marylan	
			23a. Part1. Enter the disease complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Pnysician / /Medical			i condiovos	culen	deseau	iyean
	Examiner		Due to (or as a consequence of):				1 years.
		Jer	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury)				
	scuted nd transit	Examiner	that initiated events c.				
760,	eath certificate be executed attending physician and for use as the burial-transit	cal Ex	resulting in death) Last Due to (or as a consequence of):				
387	icate l physi s the b		d				
×	n certif Inding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deli	very
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	Physician/Med	in the past 12 months? 1 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown Part II, Other significant conditions contributing to death but not resulting in the unc	darking course group in Part I	23e Did tob	acco use contribute to	the cause of death?
⊖ 7	uires tha signed d be det	by	Part is. Other significant conditions contributing to death but not resulting in the disk	denying cause given in Farti.	İ	s 2 □ No 3 □ Pro	1/
ELWOOD Records,	w require been si should	Completed			24a. Was ar	24b. Were au	topsy findings available
He He	sician: The law s certificate has b lirector, page 2 s	duc			autopsy perform	y prior to death? MANo 1 □ Yes	completion of cause of
ELMER f Vital	an: T	Be C	25. Was case referred to medical	26. Place of Death			223,170
ELI of V	hysici his ce I direc	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient			nce 6 Other (Spec	eify)
~ ~	ing Pl	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
NHISEL, Division	Attending Physician: r death. actor: After this certifics by the funeral director, i	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre-		28f. Location (Str	eet and Number or Ru	ral Route Number,
E A	after Dirac	Certification;	4 Homicide determined building, etc. (Specify)		City or Town	, State)	
BERNHISEL Divisior	To the Hospital or Attending Physician: The within 24 hours after death. To tha Funeral Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only 2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, a	and due to the ca	use(s) and manner as	stated.
-	To the Ho within 24 To the Fo	Medical	one) and manner stated.				
	With To	2	29b. Signature and title of certifier	29c. License number D 283 6 5		9d. Date signed (Month	, vay, 1541)
			30. Name and address of person who completed cause of death (Item 23a) (Type, P				
051	H5+1		MANIAR DENMARY 21 Por	ull frul- Heig	steme	1910 2/74	6
	Sta		31. Date filed (Month, Day, Year) 32. Piggistrar's Signature	will			
	Regist	rar'	APR V 1 2006 Deserve S. Sp	relis			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 5:20 PM Raymond Ellsworth BUSSARD Apri /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 29,1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2□ F 76 Yrs 217-28-5077 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 12910 Salem Avenue USA 12. Was Oecedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2K No Specify: ģ Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) laborer city government 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fit tment of Health and Mental H tent: If Item 27 is marked off Minnie K. Dunn Otho B. Bussard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 117 West Side Ave., Hagerstown, Maryland 21740 Betty Manspeaker - sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition þ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. 4/10/06 Broadfording Mem.Gdns. Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ChroNIC obstructive **Physician** Pulmonary unknown /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ bronchoge 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1□ Yes Division of Vital director. 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Medical Certification; To After this funeral of 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s efter des. ral Director: Afr 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined within 24 hours efter de To the Funaral Directo completely filled in by ti Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 58181 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE HAGERSTOWN 382 PEARAH S. CLEVELAND KODUAH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month Day Vasi Mildred A M April 5 2006 Louise Bonavries 1:40 4b. City, Town, or Location of Death 4c. County ol Death 4a. Facility Name (If not institution, give street and number) Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Hours | Min. | Feb. 9, 1 Frederick Memorial Hospital Frederick Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1□M 25 F Months 577-01-4127 88 Yrs. 1918 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1☐Yes 2☐No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Motter Avenue 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Department Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Goldie Morris Annie Laurie Hogg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Monta J. Potter / Daughter PO Box 342, Libertytown, MD 21762 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory 4/6/06 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Hirat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a on each line. Immediate Cause (Final cute disease or condition resulting in death) myrogina Due to (of as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is also as a cause). Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown

Physician /Medical Examiner

Examiner

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1 Natural 2 Accident

31. Date filed (Month, Day

5 Pending

investigation

6 2005

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ehow any injury or other traumatic event, The Madical Extrainment be inclified at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit been signed by the should be detached has e 2 s page this certificate After t death.

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown reumania 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

Certification: after death Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only ona) 29b. Signatur and title of certifier 29c. License number D51643 Shah Hron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Thonson

29d. Date signed (Month, Day, Year)

			For State Registrar		State o	f Marylan		artmen <i>rtificat</i>					giene) ()	6	2322		
	1. Decedent's Name (First, Middle, Last)										2. Date of De. Month	ath Day	Year	3. Time of Death			
	Physici /Medic		HARRIETT E.	BALDW	IN							APRIL	3	2006	10:00 A ^M		
	Examin		4a. Fecility Name (If not institu	ition, give s	street and nui	mber)		4b. City,	Town, or	Location of	of Death		4c. County of Death				
			205 CROSS CR						ESTER		04.11			N ANN			
	Funeral Director		5. Social Security Number 069–14–4946		M 2 X F	7. Age (In yrs. 85	last birthday, Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bin (Month, Da FEB. 19	y, Year)	9. Birthpl Coun NY	lace (State or Foreign try)		
	and w		Usual Residence of Decedent 10a. State 10b. Cou			10c. Cit	y, Town or L	ocation						11	Od, Inside City Limits		
	daryli f shore										1 ☐ Yes 2 X No						
	28a-	rect	10e. Street and Number	EN AN	NE 5	Cn	ESTER	10f. Zip	Code				10g, Citizen of	What Coun	try?		
21215-0036	be filed within 72 hours after death with the Maryland tall Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examinational be notified at	ä	205 CROSS CREEK COURT					21619						JSA			
		ted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Never Married 2 Married It Yes, Give Year or Dates:				16a. Dece	13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 6a. Decedent's Usual Occupation						14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry			
215	within 7% ene. than "na	ple	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)														
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Maryland	ould be filed Mental Hygis arked other atic event,		17. Father's Name (First, Middle, Last) GEORGE MILES					18. Mother's Name (First, Middle, Maid ANITA WERFT						den Sumame)			
ary	S D E E		19a. Informant's Name/Relat		pe, Print)		19b. Mail	ing Address	(Street	and Numbe	er or Rur	al Route Numbe	er, City or Town	n, State, Zip	Code)		
	27 EFF		PAUL B. BALD	WIN/H	USBAND					K CO		CHESTE	R, MD	21619			
ore	es 1 a of Hea fitem r othe		20a. Method of Disposition	on 3.⊟B	lamoval from		lace of Disp			ON		Date	20c. Location	- City or To	wn, State		
Ě	Pages ment of tant: If it		1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION CENTER, LLC. CHESAPEAKE CREMATION CENTER, LLC. O4/05/2006 STEVENSVILLE, MD														
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral San	ice Licens	e)	2. Name an TELLOW 06 SE	IS. E	ELFE	NBEI	N & NEW	NAM FUN R, MD	ERAL 1 21619	HOME, P.A.		
The state of the s	Fnysician /Medical Examiner	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Interval Between Onset and Death			
P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical Examin	Cause. Enter Underlying Cause (Despress of hold) that initiated events resulting in death) Last Due to (or as a consequence of):														
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n c	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	on:										how injury occu	injury occurred				
Division of Vital Records,		Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or To								Street and Number or Rural Route Number, wn, State)						
۵		edical Cer											ated. the cause(s)				
	To th within To th compl	Me	29b. Signature and title of certifier											Date signed (Month, Day, Year)			
			I tom on						041339 A								
	SKK		13	son who co		se of death (Item		, Print)	21	66 L							
	Sta Registi		31. Date filed (Month, Day, Y	ear)		Registrans Signa	-	A. Series	tes.								
					-7.00	2001 11/11/11	w /w	4.4									

			For State Registrar	State of N	/laryland / D		tment of H		and Mer		ene g. No. 0	6	1232	23		
	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month					Day Year			
	Physici: /Medic		SARA OCTAVIA BULLEN							APRIL 2 2006 5:25						
	Examin		4a. Facility Name (If not institution	4	4b. City, Town, or Location of Death					of Death						
			ANNE ARUNDEL M			b elevis	ANNAPOL If Under 1 Year	ANNE ARUNDEL								
n	Funeral		5. Social Security Number 212-09-4678	6. Sex 7. A 1 ☐ M 2 💢 F	Age (In yrs. last birtl 91		Months Days	If Under a	Min.	Date of Birth (Month, Day,	Year)	9. Birthip Cour MD	lace (State or ntry)	roreign		
	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel; or items 23e or 28a-f show to other traumatic event, it is Medical Examiner must be redifficated to other traumatic event, it is Medical Examiner must be redifficated to other traumatic event.		Usual Residence of Decedent		71				PIA	ak. 4,	1913	FID				
			10a. State 10b. County		10c. City, Town	or Local	tion					1	0d. Inside Cit			
		ctol	MD QUEEN ANNE'S STEVENSVILLE										1 🗌 Yes	2 X No		
		Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?			
		ral	703 MAIN STREE	12. Was Deceder	at Suprin II C	12 Wa	21666 as Decedent of H	ianania Orio	ain? /Specify		USA 14 Ray	ce - Americ	an Indian			
36		by Funeral	11. Marital Status 1 ☐ Never Married 2 ▼ Mar 3 ☐ Widowed 4 ☐ Divorced	ried Armed Forces	s? (I No	If Y	es, specify Cuba	Specify:	n, Puerto Rica	an, etc.)	Black, White, etc. Specify: WHITE					
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation							16b. Kind of Business/Industry						
215	within 7 ene. than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	or 5+)	(Give kind of work done during most of working life. DO NOT use retired)											
	Pages 1 and 2 should be filed winent of Heatth and Mental Hygien int: If item 27 Is marked other thirty or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event, Italiny or other traumatic event.	S	12	FETE	ERIA MAN				EDUCATION							
Maryland		Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)													
ž		2	CHARLES EARL HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town,										(Code)			
<u>8</u>			KENNETH BULLEN			_	X COURT				619		,			
ē,			20a. Method of Disposition		20b. Place of	Dispositi	ion (Name of		Date		Oc. Location	- City or To	wn, State			
E O			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$		WOODLA PARK	WN M	tory or other plac IEMORIAL	0	04/06/2	2006	EASTON	I_ MD				
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signatur of Fun rail Service	Licensee	7		LOWS, H	s of Facilit	y				IOME, F	.A.		
	Pnysician /Medical Examiner		FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between													
		ž 10	Immediate Cause (Final disease or condition a SUDDEN CARDIAC DEATH													
			resulting in death) Due to (or as a consequence of):													
			Sequentially list conditions.		RDIAL INF		CION									
		jue	Sequentially list conditions, and, touching to minimodate cause. Enter Underlying Cause (Disease or injury	Dise to (or a	15 a consequence	r):										
		Examiner	that initiated events resulting in death) Last	as a consequence o	of):											
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687	ificate g phy as the	edic		0.						·	1					
Вох	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Petal death	3.□E	ctopic pregnancy					23d. Date of delivery				
			in the past 12 months? 1 Yes 2 No		at time of death		other (specify)			Month			Day Y	'ear		
P.0		Phy	9 Unknown									cco use contribute to the cause of death?				
		Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION								1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown					
orc																
Vital Records,	2 2		DIABETES								24a. Was an autopsy findings avail prior to completion of cause death?					
alF			HYPERLIPID							1 ☐ Yes 2	X No	1 🗆 Yes	2 No			
ZIT.	Physician: T this certifical ral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	Hospital: 1 ☐ Inpa	atient 2 X ER/Out	testicat	3CIDOA Oth	00		heck only one 5 Resider		nor (Consid				
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ion			1 Matural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No													
Division		ifica	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
		Cert	Tomico ouilding, etc. (Specify)													
		edical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											1		
		Med	29b. Signature and title of pertific	and manner	Stated.		29c. Licens	e number		29	d. Date signe	ed (Month,	Day, Year)			
1										APRIL 4, 2006						
	<i>j.</i> (<i>f</i>		30. Name and address of person	who completed cause of	of death (Item 23a) (Type, Pr		U4			AL KTL	4, ZU	00			
	UKK		TAMES CHAMBER	TATN M D				, STE	VENSV I	LLE, M	D_216	66				
	Sta		31. Date filed (Month, Day, Year		stres Signature											
	Regist	ar	mrr	0 2000			7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JOHN ARTHUR BACHMANN MARCH 17 2006 8:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S QUEENSTOWN 289 HICKORY RIDGE DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Months Hours Director 1930 WA 75 18, 538-24-0788 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State iem 27 is marked other then "natural", or items 23a or 28e-1 show other treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Directo QUEEN ANNE'S QUEENSTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21658 USA 289 HICKORY RIDGE DRIVE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1950-If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filled within 72 hours after n and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced Year or Dates: 1971 Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SENIOR CHIEF MILITARY/U.S. NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN BAPTISTE BACHMANN KATHERINE MARTI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is m any injury or other treum <u>once</u>. ROSE A. BACHMANN/WIFE 289 HICKORY RIDGE DR., QUEENSTOWN, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State ARLINGTON NATIONAL 1 ■ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/29/2006 ARLINGTON, VA CEMETERY 22. Name and Address of Facility 21. Signature of Fineral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 KOU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION **Physician** MYCCARDIAL NONE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown After this certificate has been signed a funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Pres 2 No 3 Probably 4 Unknown Completed Diabeter Mellitus 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 10 No 1 Yes ANEMIA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? To the Hospitel or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 127388 MAR. 20, 2006 Haneman coluen

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2006 **Physician** April 9:30 A Gertrude Louise Baine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 210 Maryland Avenue Denton Caroline If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F 577-10-5314 94 Yrs Director Aug. 16, 1911 Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene insturel, or Itema 23e or 28e-fehow Important: If Item 27 is marked other than "naturel", or Itema 23e or 28e-fehow eny injury or other traumatic event, the Medical Examinat must be notified at ones. ones ones. 1 Yes 2 No Florida Lee Care Coral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33904 1441 Wellington Court USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Caucasion þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) government Supervisor accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be William Paul Beckwith Gertrude Eckstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Maryland Ave., Denton, MD 21629 William G. Beckwith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cometery, crematory or other place) Coral Ridge Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/12/2006 Cape Coral, FLA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility (00g ando Moore Funeral Home, PA, 12 S. Second St., Denton, MD 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown malnutrition 24a. Was an 24b. Were autopsy findings available prior to comptetion of cause of death? page 2 s performed? res 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the tuneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death
1 Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of centitier 29d. Date signed (Month, Day, Year) D63063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Ruglo, M 31. Date filed (Month, Day, Year) 219 South Washington Street, Easton, MD 21601

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

			1- State of Maryland / Department of Health an Certificate of Death		Reg. No. 006	12327
	Physici		1. Decedent's Name (First, Middle, Last) Mildred E. Burbage	2. Date of De Month April	Day Year 4, 2006	3. Time of Death 4:10 p M
	/Medid Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D		4c. County of Dea	
			Snow Hill Nursing & Rehab Center Snow Hill		Worches	ter
	Funeral Director		213-18-6184 84 Yrs.	Hrs. 8. Date of Bin Min. (Month, Da July 31	th y, <i>Year)</i> 9. Bir Co 1921 Mar	thplace (State or Foreign ountry) yland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary a-f sh	tor	Maryland Wicomico Hebron			1 □ Yes 2 No
	or 28.	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	ountry?
	ath wi	ral	7477 Fire Tower Road 21830		U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "natural," or items 23a or 23e-f show other traumatic event, If a Medical Examinar must be multified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 1 Yes, Sive Year or Dates: 12. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Plant Yes, Give Year or Dates:	? (Specify Yes or No uerto Rican, etc.)	Black, Whit	
21215-0036	2 hours	ted t	15. Decedent's Education 16a, Decedent's Usual Occupation		16b. Kind of Business	
215	hin 72 8. 8n "na Media	plet	(Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	working		
7	ed with ygiene. ser than	Completed	11 homemaker		own home	
Maryland	iould be filed v I Mental Hygie varked other t	Be		Name (First, Middle,	,	
Z S	should I nd Men r marke umatic	ဥ	Rufus Johnson Ella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number o	a Hill Joh		Zin Code)
S	and 2 sho salth and n 27 Is m		Aaron E. Burbage/grandson 7477 FireTower Road			LIP COGE)
5,	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	Town, State
altimore,	Page nent o ant: If ury or		1 △ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Greensboro Cemetery 04	/07/06	Greensboro	Maryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfe PO Box 160 Greens			
			23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	diac or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition ADVANCED DEMENTIA			Onset and Death
	/Medical- Examiner		resulting in death) Due to (or as a consequence of):			
	Examiner	L	Sequentially list conditions, if any, leading to immediate b. RENAL FAILURE. Due to (or as a consequence of):			
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			
Ć.	be executed sician and burial-transit	Exar	that initiated events resulting in death) Last Due to (or as a consequence of):			
8760,	ate be hysicia the bur		d			
9	The law requires that the death certificate be executed attending physician and the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:			
Box	death certifica attending ph for use as th	ian/l	23b. Was decedent pregnant in the past 12 months? 23c. It yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of de Month	ivery Day Year
	the a	ysic	1 Yes 2 No 9 Unknown 5 Other (specify)			,
P.O.	res that the de signed by the a l be detached f		Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Records,	n sign	d by		101	res 2 d No 3 □ Pi	robably 4 Unknown
00	s been si	Completed		24a. Was		utopsy findings available
Re	The la	шо		— autop perfo 1 □ Yes	osy prior to death?	completion of cause of
of Vital		Be C	25. Was case referred to medical examiner?	Death (Check only o		
Ž	Physician: this certificated director, it	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	ng Home 5 🗆 Resid	dence 6 Other (Spe	cify)
n c	ing P	on:	27. Manner of Death 1 Deatural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
isio	Vttendii death. ctor: Ai y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28f Location /9	Street and Number or Ri	ural Route Number
Division	after Direct	Certification:	3 Suicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tov		arai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p and manner stated. 29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	Fo the	₩e	29b. Signature and little of certifier 29c. License number		29d. Date signed (Mont	
			Saly M. D 006217	2	4 (5/20	06.
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
				comoice c	ITY MD	21851
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
DH.	IMH 17 Rev 1/2	5 a 8	APR 1 2006 1000 1000			
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		1 - For State Registrar	te of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygier	P006 12328	
Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last) JOSEPH GRAHAM BOWERS 4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Location of Dea	04 (Day Year 3. Time of Death 13', 45 M	
Exami	iei	SACRED HEART HO	SPITAL	CUMBERLAN	D	ALLEGANY	
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 I Usual Residence of Decedent	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		ar) 9. Birthplace (State or Foreign MARYLAND	
death with the Maryland ma 23a or 28a-f ehow	tor	10a. State 10b. County MD ALLEGANY	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 24 No	
h with the 23a or 284	ai Director	10e. Street and Number 16001 mt savage road		10f. Zip Code 21545		Citizen of What Country?	
	by Funerai	1 XNever Married 2 Married 1 N	led Forces? [Yes 2 ☐ No	Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1☐ Yes 2☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE	
within 72 hours after iene. than "natural", or Ite	Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) 1 2	lege (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry FREIGHT HAULING	
ould be filed Mental Hygid arked other atic event, II	To Be C	17. Father's Name (First, Middle, Last) COLIN BOWERS	Z PHIS.	ICIAN ASSISTANT 18. Mother's Na ALICE I	me (First, Middle, Maid	den Surname)	
d 2 sho th and th and 7 is m traum		19a. Informant's Name/Relationship (Type, Print LINDA WEIMER NIEC		ng Address (Street and Number or R CUSTER COURT BERF	ural Route Number, Cit		
permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	I IIOIII State	osition (Name of matory or other place) ND CREMATORY 4-1		Location - City or Town, State MBERLAND MD	
permit. Departi importe any inju		21. Signature of Funeral Service Licensee	22	Name and Address of Facility SOWERS FUNERAL, H		60 WEST MAIN STREET FROSTBURG MD 2153	
Physician /Medical		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not ente on each line.	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death	
ate be executed by sicion and burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	rue to (or as a consequence of):		,	0	
wrequires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medi	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
The law requires thet the ate has been signed by thoage 2 should be detache		Part II. Other significant conditions contributing	g to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
: The law re cate has bee page 2 sho	Completed				24a. Was an autopsy performed 1 Yes 2 2		
To the Hospital or Attending Physician: The jaw within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2.	ation: To Be	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Year) Property 28b. Time of Injury	ot 3 DOA Other: 4 Nursing I	ath Check only one) Home 5 Residence 28d. Describe how in		
oital or Attaurs efter de ral Directo	Certification:	4 Homicide	Place of Injury - At home, farm, str building, etc. (Specify)		City or Town, St		
in 24 hos in 24 ho ihe Fune pietely fi	ledicai	(Check only 2 Madical Examiner Or one)	To the best of my knowledge, death the basis of examination and/or indigenous stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	urred at the time, date a	and place, and due to the cause(s)	
Tot Tot com	×	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)	
H		30. Name and address of person who complete	a Roonai 9a	Print) 4 SETON DRIV	e Camber	mi (10,2006	
Sta Regista		31. Date filed (Morph 189, Year) 8 2006	32. egistrar's Signature			,	

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

					,	Certificate of	Death	Re	2 U U D	6060
	· ·		1. Decedent's Name (First, Middle, La	ist)				2. Dete of Deeth Month	Day Year	3. Time of Death
	Physicia		Lillian Elizak	eth Barnet	t			April 2	, 2006	5:15 AM
	/Medic Examin	_	4a Fecility Name (If not institution, gir				4b. City, Town, or	Location of Death	4c. County of De	eth
	-		Harborside Larl	kin & Chase	<u> </u>		Bowie	9	Prince G	eorge's
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. lest bi				Year) 9. B	rthplace (State or Foreign Country)
	Director		577-36-0537	1□ M 2ŪĀF	94	Yrs.		Feb.17,		shington, DC
	p ,	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	on or Location				10d. Inside City Limits
	aryta show	>	Delaware Suss	YOV	100. 01.9, 101	Frankfo	Frac			1√2 Yes 2 □ No
	ha M	\$	10e. Street end Number	JCA		10f. Zip Code		10	g. Citizen of What C	21
	No.	늅	10 Thatcher St.			1994	1 E	10	USA	, outries
	auth 23	era	11. Mantel Status	12. Was Decedent	Ever in U.S.			pecify Yes or No-	14. Race - Am	nerican Indian,
	the di	Š	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ 1		13. Was Decedent of If Yes, specify Cu	ban, Mexican, Puèri	o Rican, etc.)	Black, Wh	ite, etc.
2	i', or	<u>A</u>	3 Widowed 4 Divorced	If Yes, Give X Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:		Specify:	White
ş	2 hou	8	15. Decedent's E		166	. Decedent's Usual Occu	upation	1	6b. Kind of Busines	s/Industry
212	riticate be axecuted III Begas 1 end 2 should be filad within 72 hours efter death with the Maryland Department of Health and Mantal Hygiana. Inportant: If item 27 is marked other than "naturel, or items 23s or 28s-f show as the burial-transit and injury or other traumatic event, the Medical Evantries must be notified at the burial-transit and the property of the	음	(Specify only highest gr Elementery/Secondary (0-12)	ade completed) College (1-4or 5	i.a.)	(Give kind of work done life. DO NOT use retir	e during most of woi ed)	rking		
7		E	12th	00110g0 (1 401 0		Homemaker			Own Hom	e
פ	othe othe	Se C	17. Father's Name (First, Middle, Las.				18. Mother's Nar	ne (First, Middle, M	aiden Surname)	
<u> a</u>	Aanta fanta fanta rkad rkad	Jo I	Augustus Becl	ker			Mary	M. Goetz		
a	shot and N		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Address (Stree	et and Number or Ru	urel Route Number,	City or Town, State	, Zip Code)
Σ	end 2 sh aalth and n 27 is m		Elizabeth Tubbs	s / Daughte	er	10 Thatcher	r St. Fran	nkford, De	elaware	19945
o C	tam tam		20a. Method of Disposition	Demonal from State	20b. Place o	of Disposition (Name of ery, crematory or other pl	lace)	Date 2	0c. Location - City o	or Town, State
Ĕ	it. Pagas rtment of rtant: if if njury or		1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci		Metro	politan Crem	natory	4-4-06	Alexandri	a, VA
Baltimore, Maryland 21215-0020	mit.		21. Signeture of Funeral Service Lice	nsee / /	9	22. Name and Add	ress of Facility BI	EALL Fune	ral Home	
n	g G E S		Minima	ANT IL	2001	6512 NW 0		Bowie, N		
	Eas H		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do	not enter the mode of dy	ying, such as cardia	or respiratory arre	st,	Approximate Interval Between
and the second	Physician		Shock, or near railure. List only	One cause on each in	16.					Onset and Death
mil.	/Medical Examiner		Immediate Cause (Final disease or condition	Ventri	cular F	ibrillation				30 Minutes
-	Examiner		resulting in death)	a	Due to (or es e	consequence of):				+
	D #	ine.	-	Ischemi	.c Card:	iomyopathy				3 Years
	ecute and trans	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	U	,	consequence of):				
Ö,	oe ax	<u> </u>	cause. Enter Underlying Ceuse (Disease or injury	Coronai	ry Artei	ry Disease				20 Years
09/89	ate t	흥	that initieted events resulting in death) Last		Due to (or as a	consequence of):				
		ΣI		d						
80	ath c	an l								
-	tha e	ysic	Part II. Other significant conditions	contributing to death b	ut not resulting	in the underlying cause of	given in Part I.	23b. Did tob		te to the cause of death?
0.	hat the datec	F	Hypertensio	on				1 □ Ye	s 2∏ No 3□	Probably 4 Unknown
Division of Vital Records,	signe d ba	ğ						24a. Was an	autonsy 24b	. Were autopsy findings
Ö	raqu	etec	Alzheimers	s Disease				perform	autopoj	available prior to completion of cause
Sec.	hes b	Ē							o Victoria de la compansión de la compan	of death?
=	: Tha	ខ		_				1 TY	**	1 ☐ Yes 2 ☐ No
<u> </u>	clan Sertifi actor	Be	25. Was case referred to medical examiner?	Hospital:			ther:	ath (Check only one		
0	To the Hospital or Attanding Physician: The law requires that the death ca within 24 hours effer death. To the Funeral Director After this certificate hes been signed by the eltendi complataly filled in by the funeral director, page 2 should be deteched for use	P	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatie		utpatient 3 DOA	4 XI Nursing r	lome 5 ☐ Resider 28d. Describe hove		pecify)
ב	Ing f	5	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury W	ork? □Yes 2□No		,,	
<u>S</u>	daath daath tor: / the	Cat	3 Suicide 6 Could not	De Diana et lai	ury - At home f	arm, street, factory, office		28f. Location (Str.	eet and Number or	Rural Route Number,
<u>></u>	ofter a	H	4 ☐ Homicide determined	building, et	c. (Specify)	am, shoot, lastery, eme		City or Town,		
_	To the Hospital within 24 hours e To the Funeral complataly filled	edical Certification:	29a. Certifier 1. Certifying P	hysician: To the heet	of my knowledn	e, death occurred at the	time, date and plece	and due to the car	use(s) and manner	as stated.
	To the Hospital within 24 hours. To the Funeral complataly filled	dic	(Check only 2 Medical Exa	miner: On the basis of end manner st	examination e	nd/or investigation, in my	opinion, death occu	urred at the time, da	te and place, and d	ue to the cause(s)
	othe omple	Me	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Mo	nth, Day, Yeer)
	- 5 - ō		Amir. P	lan.	0	D	0016197		April	3, 2006
1	10		30. Name and eddress of person who	completed cause of d	eath (Item 23e)	(Type, Print)				
K	J (3)		Dr. Andres Lar				nham M-	lama 20	700	
	Sta	te.	31. Date filed (Month, Day, Year)	2. Registr	ar's Signature	vern Rd. La	HIGHI, MAY	y± and 20	/06	
	Registr		APR 0 5 200	6 Kline	JE ,	Charles				

DHMH 16 Rev 6/95

		•	For State Registrar	State of Ma	arylan		artmen rtificat			ind Me		giene Reg. No.		2330
*	Physici /Medic		1. Decedent's Name (First, Middle, La Arthur Ke	st) rman Baylo	r						2. Date of Dea Month March	Day	Year 2006	3. Time of Death 10:08 P ^M
	Examir	100	4a. Facility Name (If not institution, giver Prince George		al		4b. City,		Location of Cheve:				ounty of Dea Prince	
数: . 读者	Funeral Director		579-36-3455	ex 7. Ag ☐XM 2☐ F	e (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da June 6,	y, Year)	-	thplace (State or Foreign ountry) irginia
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County DC		10c. City	y, Town or Lo	ocation		Wash:	ingto	on			10d. Inside City Limits 1
	or 28a-	Director	10e. Street and Number		1		10f. Zip				10g. Citizen of What Country?			ountry?
36	be filed within 72 hours after death with the Maryland ital Hygiene. ed other then "natural", or Items 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral	1000 − 47th : 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Types 2 1 If Yes, Give Year or Dates:	Ever in U.	.S. 13.	Was Dece If Yes, spe	dent of H	20019 ispanic Orig in, Mexican, Specify:	gin? (Spe , Puerto F	cify Yes or No lican, etc.)	- 14	Race - Ame Black, White	States erican Indian, te, etc. Black
15-0036		Completed	15. Decedent's E (Specify only highest gr.	ade completed))	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done o	during most	of working	g	16b. Kind	of Business	/Industry
<u>5</u>	e filed with at Hygiene i other the vent, the	Be Com	Elementary/Secondary (0-12) 6th 17. Father's Name (First, Middle, Last	College (1-4or 9			Tr	uck	Drive 18. Mother		(First, Middle,	Maiden Si	Priva:	te
Maryiand	Permit. Pages 1 and 2 should be bearnit. Pages 1 and 2 should be pagariment of Health and Menta mportant: If item 27 is marked iny injury or other traumatic evance.	To	John Wo	esley Bayl Type, Print)	or	19b. Maili	ng Address	(Street	and Number	r or Rural	Uzzie		Lewis	Zip Code)
e, Na			Betty J. Bay1	or/Wife	20h P	100			Place		E. #3,		ation - City or	20019
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		0	emetery, crei	matory or c	ther plac					iitlan	
Balti	permit. Departin Imports any inju		21. Signature of Funeral Service Lice	Leway	TI	22			ss of Facility Bennii		ewart 1., N.E	Funer	al Hor	-
,/60,	Physician /Medical Examiner price pr	lical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. C. C. Due to (or as d	a consequence a				cilul cer					Interval Between Onset and Death
HOK P	der th certifi e aftending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Feta	Ideath 3[□Ectopic p □ Other (sp					23	d. Date of de	livery Cay Toan
	quires that n signed b uld be deta	þ	Part II. Other significant conditions Analysis		ut not res	ulting in the u	nderlying o	ause giv	en in Part I.			obacco use Yes 2 🗆		o the cause of death?
Ĭ	The had age	Completed									24a. Was autor perfo 1 \(\text{Yes} \)	rmed?	24b. Were an prior to death?	utopsy findings available completion of cause of
Vita	hat the death certificate be executed to the death certificate be executed to the death and Meritary or other traumatic to the death of the attention of the death of the deat	Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital:	ant 2 🗆	ER/Outpatier	nt 3 🗆 D0	Oth	00		Check only one		Other (Sp.	noutic)
ion of	nding Phy ath. r: After this e funeral d	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ıry	28b. Time o Injury		28c. Injun Wor		2	8d. Describe t			sury)
Divis	tal or Atters after design Directors	Certification:	3 Suicide 6 Could not t 4 Homicide determined		ury - At ho c. (Specif	ome, farm, str	reet, factor	y, office		2	8f. Location (S City or Tox		Number or R	ural Route Number,
	Hospil 24 hour Funer etely fill.	edical	29a. Certifier 1X Certifying P (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis of and manner st	f examina	wledge, deat ition and/or in	h occurred vestigation	at the tin , in my o	ne, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) a date and p	nd manner a lace, and due	s stated. e to the cause(s)
)	To the within To the compl	Me	29b. Signature and title of certifier	adt n	10		- 1		i 88 3	3			signed (Moni	th, Day, Year)
((4)		30. Name an address of person who HEMA PYADLAO					5 1.	AN HX	m-	M.D 2	S.		770=15
			31. Date filed (Month, Day, Year) APR 0 4 2006	732. Registi			B	7		-				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Cornachia APRIL 11 2006 16:15 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND 8. Date of Birth Month, Day, Dec 12, 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 214-14-7615 84 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Itame 23a or 28s-f show any Injury or other traumatic event, the Medical Examinar must be motified at once. Allegany MD Cumberland 1 Ves 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 401 Springdale Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white WWII 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) electrician railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marco Cornachia Josephine Cornachia ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Ashley Street Cumberland MD 21502 19a. Informant's Name/Relationship (*Type, Print*)
Sandy Shearer daughter 20b. Place of Disposition (Name of cemetery crematory or other p St. Mary's Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4/17/2006 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral rvice Licensee 22. Nam Scaffelli Fülleral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Antery **Physician** oronary 10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-translt The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 2 XNo certificete 1 Yes : After this certifice s funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 KER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.
To the Funeral Diractor: Al 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of defilier 29c. License number 29d. Date signed (Month, Day, Year) DU 0 33 280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Med. Bldg, Cumber land, MD Johnson Heights 31. Date filed (Month, Day, Year) 32. Megistrar's Signature State **APR 1 9** 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 2006 ELAINE MARTHA CAPPA 8:05PM M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner EASTON TALBOT 29474 CORBIN PARKWAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 10, 1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10M **X**)F Months Days Hours 73 Yrs. DELAWARE 220-28-1528 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits show 77 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, tre Medical E∗a⊤iner must be notified at 1 Yes 2 □ No Director TALBOT EASTON 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 29474 CORBIN PARKWAY 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2X Married Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 TAX PREPARER TAX PREPARATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fill and Mental H Be MARY R. WILLIAMS JOSEPH J. PETALIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is JOHN T. CAPPA, SR./HUSBAND 29474 CORBIN PARKWAY, EASTON, MD 21601 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If its any injury or of once. CHESAPEAKE CREMATION CTR 4/8/2006 STEVENSVILLE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA m. Ostanske C.fS.P. 200 S. HARRIOSN ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE Physician ALNA /Medical **Examiner** pembergreporic pur pura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate Yes 2ENO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 2 this ieral Director: After the filled in by the funeral 27. Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗆 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LUDWIG J. EGLSEDER, III M.D. 503 CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Month, Day, Year) egistrar's Signature State APR 0 7 2006 Registra

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** DAVID WARREN CUMMINGS MARCH 30, 2006 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 100 BRYANS CHANNEL WAY QUEENSTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 73 008-24-3110 30, 1932 FLUsual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits other then "neturel", or iteme 23a or 28a-f ehovent, the Mudical Examiner must be notified at 1 ☐ Yes 2 👿 No Director MD QUEEN ANNE'S QUEENSTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21658 100 BRYANS CHANNEL WAY USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1958—1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CIVIL 12 5+ **ENGINEER** permit. Pages 1 end 2 should be file Deperment of Heelth and Mentel Hy importent: if Item 27 is marked oth eny injury or other treumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM WARREN CUMMINGS ELEANOR F. JAQUITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 BRYANS CHANNEL WAY, QUEENSTOWN, MD LOIS I. CUMMINGS / WIFE 20b. Place of Disposition (Name of cametery, crematory or other place)
CHESAPEAKE CREMATION
CENTER, LI.C. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Bunal 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/31/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD, CHESTER, MD 21619 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Approximate Interval Between ich as cardiac or respiratory arrest. nset and Da Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit the ettending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 Yes 1 ☐ Yes Hospital or Attending Physician: 4 hours effer death. Funeral Director: After this certifice director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes 2 No ٩ 3 DOA 5 Residence 6 Other (Specify) funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours e To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medicai completely (Check only one 29b. Signature and little of certi 29c. License number 29d. Date signed (Month, Day, Year) Mame and address (Item 23a) (Type, Print 32. Regis 31. Date filed (Month, Day, Year) State WAR 3 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** РМ April 11 2006 1430 Lawrence Steven Cox /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil Union Hospital E1kton If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year Months Days Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1**∑**M 2□F April 27. Maryland Director 220-74-5818 46 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28e-f ehow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Cecil Maryland E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code ō or itema 23a 143 Kirk Road 21921 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced Black "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Colfege (1-4or 5+) Elementary/Secondary (0-12) s 1 and 2 should be filed within the sith and Mental Hygiene. Item 27 Is marked other then 12 Clerk Chemical 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Clarence Oscar Cox Sally M. Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If item 27 is rr eny injury or other traum once. Sally M. Cox/Mother 143 Kirk Road, Elkton, Maryland 21921 20a. Method of Disposition 20b. Place of Disposition (Name of April 15, 20c. Location - City or Town, State Griffith A.U.M.P. 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2006 Cedar Hill, Maryland Church Cemetery 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21. Signature of Funeral Service Licensee -0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between H and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit 6 ue to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be deteched for □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page this certificete 1 Yes 2 1 No of Vital After this certifice funeral director, or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl one) 29b. Signature and title 29c. License numbe 29d. Date signed (Month, Dey, Year) 515 completed cause of death (ftem 23a) (Type, Print) 30. Name and addres John R. Mulvey, M.D., 111 West High Street, Suite 309, Elkton, Maryland 21921 31. Date filed (Month, Day, Year) . 32. Restrar's Signature State Registra

		for State Registrar	State o	of Marylar		artment of <i>tificate of</i>		d Mental Hy	giene Reg. No	2nn.	12335
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/Medic	al .	Ronald Alan Calla				45 O'S T		April		2006 County of Death	11:21 A M
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Funeral		5. Social Security Number 6.	Sex	7. Age (In yrs.		If Under 1 Yea	r If Under 24 I		th		place (State or Foreign
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and and m 27		Carol B. Callahar	ı / Wife		_	Rooks Ct	. Frede	rick, MD			
permit. Pages 1 and 2 should be filed within Department of Heelth and Mantal Hygiene. Important: If item 27 is marked other then eny injury or other treumatic event, the Manual Hygiene.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 [State	cemetery, cren	cremato				ocation - City or T	
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CALLAHAN

		1- For State of Maryland / Depart Certif	ment of Health and Mental	Hygiene Reg. No. 006 2337
		1. Decedent's Name (First, Middle, Last)	2. Date of	of Death 3. Time of Death
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_xa	miner	10867 PAM DRIVE	WALDORF	CHARLES
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and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati	on	10d. Inside City Limits
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Baltimore, permit. Pages 1 am Department of Heal Important: If item 2 any injury or other		t√Burial 2 □ Cremation 3 □ Removal from State cemetery, cremator 4 □ Donation 5 □ Other (Specify) MARYLAND VETI	ERANS CEM. 4-18-06	6 CHELTENHAM, MD
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Physer this eral di	Ë	- I I I I I I I I I I I I I I I I I I I	28c. Injury at 28d. Des	sidence 6 Other (Specify)
ision Attendin death. ctor: Aft	ate	Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No	
Division of to Attending Phy atter death. Director: After this in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	factory, office 28f. Locatio	on (Street and Number or Rural Route Number, Town, State)
itel o	Se			
Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death. To the Fueneral Director. After this certific completely filled in by the funeral director.	edical	29a. Certifier Ad Certifying Physician: To the best of my knowledge, death occ (Check only one) 20a. Certifier Ad Certifying Physician: To the best of my knowledge, death occ on the basis of examination and/or investion	curred at the time, date and place, and due to gation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
To the within 2 To the complet	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Manth, Day, Year)
		1 Math	D78.3 L5	4/13/06
in		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	1 -01 6 11	M 1-0641
0	State	31. Date filed (Month, Day, Year) 32. Pecistrar's Signature	CI COL 10	010
Reg	State	APR 1 8 2006 Blogue & Son	A S	
	Suai			

			for State of Man		artment of H		tental Hygie, Reg.	ZIHIH	12338
	Physici		Decedent's Name (First, Middle, Last) Sarah K	. Davidsor	n		2. Date of Death Month April 3,	Day Year 2006	3. Time of Death 3:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	APILI J,	4c. County of De	ath
			Peaceful Life Assisted Lives 5. Social Security Number 6. Sex 7. Age (Ving In yrs. last birthday)		Marlboro	9 Date of Birth		George's
	Funeral Director		E	81 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye Oct 7, 19	924 Sc	ithplace (State or Foreign Country) Outh Carolina
	yland now		The state of the s	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Be-f sl	ctor	Maryland Prince George's		New C	arrolltor	1		1 XYes 2 ☐ No
	3e or 2	il Directo	10e. Street and Number 5813 Oland Drive		10f. Zip Code	784	10g.	Citizen of What C	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	er in U.S. 13. \		ispanic Origin? (Spon, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	nerican Indian,
9500-51212	n 72 hours after death with the Maryland "neturel", or Items 23e or 28e-f show	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ŽANo	Specify:		Specify:	White
ב	"netu	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occup- kind of work done	ation during most of work l)	ing 16b	. Kind of Busines	s/Industry
717	filed within 72 Hygiene. Ither then "net	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Office Cl			Privat	æ
<u>D</u>	m = 0 %	BeC	17. Father's Name (First, Middle, Last)				e (First, Middle, Maid	den Sumame)	
yland	nd 2 should lith and Men 27 Is marke r treumatic	^L	Robert S. Carey				ne Matthe		
Mar.			19a. Informant's Name/Relationship (Type, Print) Kathleen Herring (Daughter)				al Route Number, Ci Vie MD 207		Zip Code)
Baitimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo- cemetery, cren	osition (Name of matory or other plac	e) [Date 200	. Location - City o	r Town, State
	it. Pag irtment irtent: njury		` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Chesapeal	ke Cremat	ory 4/6/2	2006 E	eltsvill	Le, MD
ğ	Dep Imp any		Patricia Latinia	, (9013 Anna	wolis koa	ıdon/нате id. Lanhau	Funeral MD 2070	Home
	E 4358		23a. Part1. Enter the disease, or complications that caused the						
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Settury	re disor	rder			le Funeral Home ham MD 20706	
	/Medical Examiner		Due to (or as a c	re dusor consequence of): nfarct	de . a.	ti a			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		our cer	1100			10003
	rificate be executed ng physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a c.						
68/6 0,	be ex Sician burial		Due to (or as a c	onsequence or):					
89	tificate ig phy as the	ledicai	d						
.c. Box	death ce e attendii ed for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at time 4 □	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
7	uires that the des	by Ph	Part II. Other significant conditions contributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute	to the cause of death?
cords,	law requires that the as been signed by th 2 should be detache	ed b	Hypertension, recent i	mari	1 trac	t	1 ☐ Yes	2 □ No 3 □ F	Probably 4 Dunknown
e E	sicien: The law re certificate has be irector, page 2 sh	Completed	infection				24a. Was an autopsy performed	prior to death?	autopsy findings available completion of cause of
Vital	ysicien: ' is certifica director, p	BeC	25. Was case referred to medical examiner?			26. Place of Death	1 ☐ Yes 2 🗹	NO ILITE	s 2□No
010	this ald	P	1 ☐ Yes 2 ② No Hospital: 1 ☐ Inpatient			4 Nursing Ho			ocity 6 roup home
	ftei	ation	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Y	(ear) Injury	Work	Yes 2 □No	28d. Describe how in	njury occurred	
DIVISION	2 4 5	Certification:	a Coulette 6 Could not be	· At home, farm, stre (Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,
	ne Hospitel or n 24 hours afte te Funerel Dir yetely filled in	Medical C	29a. Certifier (Check only one) 1 Dr. Certifying Physicien: To the best of real name of each of each of manner state.	xamination and/or inv	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cause ed at the time, date	e(s) and manner a and place, and du	us stated. le to the cause(s)
	To the To To To To To To To To To To To To To	Me	29b. Signature and title of certifier	0	29c. License	number	29d.	Date signed (Mor	oth, Day, Year)
	4.5)		Yara J. Musson	Lino		6992		13/06	
	Til E	-	30. Name and address of person who completed cause of deal Tara Muscurich 1438	Defense	1	Ganb	rdls, Mil) 2103	54
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's APR 0 5 2006	Signature	J				
	riegisti		APR 0 5 2006 Beaut	and .					

			For State Registrar	State of Ma	ryland		irtment of H <i>tificate of l</i>			iene	16 12339	
N.	Physicia	an	1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat Month	h Day	3. Time of Death	4
			Oma Dale 4a. Facility Name (If not institution, give	a street and number)			4b. City. Town, or	Location of Death	March	28 20 4c. County	006 2:50 a	_
	Funeral	er -	Prince George C	community H	(In yrs. las	st birthday)	Cheverly If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Prince	e George 9. Birthplace (State or Foreig Country)	n
	Director		404-28-1603 Super Section 1		84	Yrs.			Dec. 22	1921	Kentucky	
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits	
	Many e-f sh	ţo	Maryland Prince G	eorge	East	Hyat	tsville				1 Yes 2 □ No	>
	th the	le	10e. Street and Number				10f. Zip Code		1	0g. Citizen of V	What Country?	
	23a (23a	ral	4803 Edmonston Ro	ad				781		ISA		
0000	urs after des al', or Iteme Exeminer m	þ	11. Maritaf Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I □ Yes 2⊠ No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - American Indian, ck, White, etc. y: White	
בָּ כ	72 ho natur lice	ted	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	lent's Usual Occup	ation during most of worki	ina	16b. Kind of Bu	usiness/Industry	_
V	ithin 96.	nple	Elementary/Secondary (0-12)	College (1-4or 5-		life. L	DO NOT use retired	1)	9			
7	Hospital or Attending Physician: The law requires that the death certificate be executed the filed or Attending Physicians. The law requires that the death certificate has been signed by the eltending physician and the following physician and the filed in by the funeral director, page 2 should be detached for use as the burial-transit or as the burial-transit or as the burial-transit or as the burial-transit or as the burial-transit or as the purial-transit or as the burial-transit or other traumatic event, it is the standard or as the burial-transit or as the buri		8 17. Father's Name (First, Middle, Last)			Homema	aker	18. Mother's Name	/First Middle	Own Ho		_
yiand	d be intail.	m	William Jones	'				Mary Jac		Maiden Sunian	10)	
Š	should nd Me mark matic	F	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address (Street	and Number or Rura		. City or Town.	State, Zip Code)	_
Ma	Pages 1 and 2 s nent of Health an snt: If item 27 Is ury or other trau		Clara Louise Ha		ghter							
ā,			20a. Method of Disposition				sition (Name of natory or other place				City or Town, State	_
Ē			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				1n Cem.	4/1/	06	Brentwo	od, MD	
Бант	permit. Depertra Importa eny inju		21. Signature of Funeral Service Licer	Cessele	_	3	401 Blad	ss of Facility Ft ensburg R	. Lincol	In Fune:	ral Home	
1974	307.11		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arr	est,	Approximate Interval Between	
10 a	Physician		fmmediate Cause (Final disease or condition	a Cardiomy							Onset and Death	
			resulting in death)	Due to (or as a								_
	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Hyperter	ısive	Rena1	disease					
-	ed isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a		ence of):						
	end end II-tran	that imitated events resulting in death) Last Cause (or as a consequence of):								_		
8/60	sicien burié	alE	l	d								
200	ificate g phy as the			d								
O. Box	he death cert the ettendin ched for use	ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the Live birth 4 Pregnant at 9 Unknown	2 Fetal o	Fetaf death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year		
Ž.	5 69 ₽		Part fl. Other significant conditions of	contributing to death bu	ıt not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use cont	tribute to the cause of death?	
S	n sign	Q D	Atrial fibrilati	ion					1 🗆 Y	es 21€No	3 ☐ Probably 4 ☐ Unknow	n
ecords,	s bee	olete							24a. Was a	n 24b.	Were autopsy findings available	9
r	The la	E O							autops perfor	med?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
VITA	ian: rtifica ctor, p	0	25. Was case referred to medical					26. Place of Deat			22110	-
<u> </u>	hysic his ce I direc	To	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🛣 Inpatie	nt 2 🗆 E	R/Outpatier	it 3□ DOA Oth	er: 4 🗆 Nursing Ho	me 5 Resid	ence 6 🗆 Oth	ner (Specify)	
	After After fune		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio		Year)	28b. Time of fnjury	Wor	yat k? Yes 2 □No	28d. Describe h	ow injury occur	red	
DIVISION	2 = = -		3 Suicide 6 Could not be determined		ury - At hon :. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	per or Rural Route Number,	
	To the Hosp within 24 hou To the Fune completely fil	ledical	(Check only 2 Medical Examone)	nysician: To the best of minar: On the basis of and manner sta	examination	rledge, deatl on and/or in	vestigation, in my o	pinion, death occur	red at the time, d	ate and place,	and due to the cause(s)	
	To To	Σ	29b. Signature and title of certifier	1/1/	72 1	M.	29c. Licens			_	d (Month, Day, Year)	
	(2)		17/4-1	LOKE	W	-111		12863	M	larch 30	0, 2006	
1	(5)		30. Name and address of person who Hassan Molavi, M					erly. MD '	20785			
190	Sta	ate	31. Date filed (Month, Day, Year)									
	Regist		APR 0 4 200	6 Registra	K	Ans	E)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** рм Nevart Essavan April 1, 2006 1:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care-Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 🔀 F Yrs 93 Director 218-54-6117 1912 Egypt Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Modical Examinar trust be notified at 1 Tyes 2 XNo Maryland Montgomery Silver Spring Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9417 Curran Road 20901 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite may njury or other traumatic event, tre Modest Exacult and 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: Specify: White þ 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Aris Torossian Marie Patapanian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hermine Gakavian/ Daughter 9417 Curran Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 6, 1 □ Burial 2 □ Cremation 3 □ Removal from State 2006 Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee Franceis Address Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 Lober ann 23a. Part 1. Enter the disease, or complications that caused the drafth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementia Years /Medical Due to (or as a consequence of) Examiner 2-3 Months Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physicien and s the burial-transit requires that the death certificate be executed 1 Month Dehydration resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificete has autopsy performed? 2 No 1 Yes 2₺ No 1 Yes to the Hospital or Attending Physician: After this certification, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of perso

Day, Year)

0 5 2006

31. Date filed (Month, Da

Coase

Name and address of perso // o completed cause of death (Item 23a) (Type, Print)
 Darryl Hill, M.D. 13635 Baltimore Avenue, Laurel, Maryland

32. Signature

MURI

0053235

		1	For State Registrar	•	epartment of Health and N Certificate of Death	rientai mygiei Reg.	2000	12341
T.	Physicia		Decedent's Name (First, Middle, Last) Edward Paul Fi	tzgerald		2. Date of Death Month April 13	Day 2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stree Devlin Manon N	et and number)	4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegany	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	tay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Apr 20	-	place (State or Foreign ntry) Tryland
	100		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
	Mary Hed	tor	MD Allegany	Rawli	ngs			1 ☐ Yes 2 ☐ No
	3a or 28	Il Director	10e. Street and Number 18707 McMullen	Hwy.	10f. Zip Code 21557	1	Citizen of What Cou	ntry?
130	72 hours after death with the Maryland Instural, or Items 23s or 28s-f show dical Establish in ast be rollified at	by Funeral	11. Migrital Otatas	Was Decedent Ever in U.S. Amed Forces? 1 GYes 2 □ No 1953 If Yes, Give Year or Dates: 1957	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.
215-0036	I within 72 hours iene. r then "netural", tre Medical Eru	Completed	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	on 16a. D ompleted) (0	ecedent's Usual Occupation Sive kind of work done during most of work fe. DO NOT use retired) Ostal Carrier	1	. Kind of Business/Ir	Service
12 pu	oe filed within al Hygiene. J other than ovent, I've Me	Be Cor	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Mai	den Surname)	
Maryland	Pages 1 and 2 should bent of Health and Ment of Health and Ment int: If Item 27 is market ury or other traumatic	ပ	Edward Michael 19a. Informant's Name/Relationship (Type.		Margar Mailing Address (Street and Number or Rui	et (Gall		
Baitimore, Ma			Michael E. Fitz	2011	707 McMullen Hwy			
			20a. Method of Disposition 1 □ Burial 2 뮻Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Place of D	or crematory or other place) ugh Crematory pr.	Date 20d	c. Location - City or T	own, Stete
Baltil	permil. Page Department Importent: I any injury o		21. Signature of Funeral Service Licensee	al	22. Name and Address of Facility H 1302 National H	afer Fun	eral Ser	
微	* * * * * * * * * * * * * * * * * * * *	8 -	23a. Part1. Enter(the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final			or respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence	heime Den			4yr
. /	ed ist	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
68760,	ficate be executed physician and is the burial-transi	al Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):			
P.O. Box 687	The law requires that the death certificate are basen signed by the attending phyyage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetel death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delin	very Day Year
	ires that t signed by I be deta	by	Part II. Other significant conditions contri	-			cco use contribute to	the cause of death?
Division of Vital Records,	al 2	Completed	- The first first	Lygorobons		24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
a E	n: The		Of Management of a display		OC Place of Poo	1 Yes 2 Lath (Check only one)		2 🗆 No
Ş	Physician: r this cartificaral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outs	Other	ome 5 Residence	e 6 □Other (Spec	rify)
on of	Attending Phy ir death. ector: After this by the funeral c	-		28a. Date of Injury 28b. Ti		28d. Describe how	injury occurred	
Divis	al or Atter after dea Director d in by the	Certification:	a Could not be	28e. Place of Injury - At home, fare building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ien: To the best of my knowledge, r: On the basis of examination and and manner stated.	death occurred at the time, date and place /or investigation, in my opinion, death occu	e, and due to the caus erred at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
h	To th To th	Me	29b. Signature and title of certifier		29c. License number	5 6	Date signed (Month	
	5+1					7312	1502	
ľ	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

Registrar

APR 1 9 2006 June 18 July ORIGINAL

		1	State of Maryland / Department of Health and Mer State Amend #27, perME, g868, 6/18/07 TT Certificate of Death	ntal Hygi	ene 0 0 6	12342
	Physicia	_	1. Decedent's Name (First, Middle, Last)	Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 910 ASA TON Rd 4b. City, Town, or Location of Death	APT -	4c. County of Death	mery
	Funeral Director		219-68-7378 1 Months Days Hours Min. No.	Date of Birth (Month, Day,)	Year) Coun	lace (State or Fbreign stry) 7land
e Maryland	Se-f show	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Ashton			0d. Inside City Limits 1 ☐ Yes 2 🖾 No
with th	e or 20	Dire	10e. Street and Number 910 Ashton Road 20861	10	g. Citizen of What Cour USA	itry?
1215-0036 within 72 hours after death with the Maryland	l', or items 23 zaminer mus	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
21215-0036 d within 72 hours af	sne. Ihan "natura na Medical E	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 12 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) Cabinet Maker	1	6b. Kind of Business/In	dustry
and 2	antal Hygie ced other c event, II	To Be Co	17. Father's Name (First, Middle, Last) William F. Fearson 18. Mother's Name (First, Middle, Last) Dorothy L.			
Maryland		ř	19a. Informant's Name/Relationship (Type, Print) Debra P. Fearson/Wife 19b. Mailing Address (Street and Number or Rural Fig. 910 Ashton Road, Ashton			Code)
Baltimore,	nent of Hean		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Removal from State 1 □ Date of Disposition (Name of cametery, crematory or other place) 1 □ Date of Disposition (Name of cametery, crematory or other place) 1 □ Date of Heaven Cemetery	8,	Oc.Location-City or To Silver Spri	own, State ng, Marylan
Balti	Departr Importe any inju		21. Signature of Funeral Service Licenses Figure 12 Appreniage Appress of Publishers Function Functio	W, Silv	ver Spring,	MD 20901
1760, ut be executed u	eath certificate be executed //Medicale be executed //Medicale betending physician and iter use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or neshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	900	ing	Interval Between Onset and Death
O. Box 68	/ the ettending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown		23d. Date of delive Month	ery Day Year
D §	sign d b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to to s 2 No 3 ☐ Prot	he cause of death? pably 4 □Unknown
I Rec	ete hes b page 2 sl	Completed		24a. Was am autopsy perform 1 🗆 Yes 2	24b. Were auto prior to co death? 1 \(\text{Yes} \)	opsy findings available mpletion of cause of
of Vita	is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 1 No Other: 4 Norsing Home	1.	nce 6 Other (Special	(y)
vision of	After Fune		27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 28c. Injur		w injury occurred C	
5	irs after de rei Directo	Certification;	home	sh tom	reet and Number or Run , State) 9 10 19 , mD 20	561
]	the old	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one) 2 Shadignature and title of certifier 2 Shadignature and title of certifier 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and check only one)	I at the time, da	use(s) and manner as s ite and place, and due t Od. Date signed (Month,	o the cause(s)
	5		1 20 KA COM DONE 120428	F 12	Ppr 2.	2006
			Ira ~ BRECKER, MD DME Silver Sprin	ne or	0 2096	2
S.	Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 50 / Me did The NGREC NER, MD DME 5, (Ver Spring 31. Date filed (Month, Day, Year) APR 0 5 2006 32 Registrar's Signature	<i></i>		

DHMH 17 Rev 1/2001

Registrar

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	une irec		
pur	*	2	

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If them 27 is marked other than "neturel", or thems 23a or 28e-f show any Injury or other treumetic event, It e Modical Exaculter man be notified at once.

Baltimore, Maryland 21215-0036

Betty Flamer

Physician /Medical **Examiner**

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Innest director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

1	For Stata Ragistrar	0.0.0 0	, , , , , , , , , , , , , , , , , , , ,	C	ertificate	of E	eath	.,		Reg. No	JUb	12344
1	. Decedent's Name (First, Middle, Last)								2. Date of Dea	ath		3. Time of Death
ı	Betty Jean I	lamer							April	_{Ба}		3:30 AN
4	a. Facility Name (If not institution, give		er)		4b. City, T	own, or	Location o	of Death	1110	7	c. County of Dea	
	Genesis HealthC		he P	ines			ton				Talb	ot.
5	. Social Security Number 6. Ser		Age (In yrs.				If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day 08-23-1	, Year) Co	thplace (State or Foreign untry)
	Jsual Residence of Decedent											
	0a. State 10b. County			y, Town or	Location							10d. Inside City Limit
$\overline{}$	Maryland Talbot Oe. Street and Number		Las	ston	10f. Zip (Code			· · · · · · · · · · · · · · · · · · ·	10a. C	itizen of What Co	ountry?
	312 Salmons Ave.					2160	1			-3	USA	
1	1. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13	B. Was Decede	ent of His	spanic Ori	gin? (Sp	ecify Yes or No-	.	14. Race - Ame	
	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 If Yes, Give Year or Date	No.		1 ☐ Yes 2		Specify:	i, rueit	rican, ec.,		Black, White	
-	15. Decedent's Edu (Specify only highest grad			(Gi	edent's Usual	done di	urina mos	t of work	ting	16b. l	Kind of Business	Black VIndustry
	Elementary/Secondary (0-12)	College (1-4	or 5+)	life	. DO NOT use	orke				۸	11en Fo	oods
	7. Father's Name (First, Middle, Last)			1	TILE W			r's Nam	e (First, Middle,			Jogs
	Daniel Lee Sm	nith. Sr						C1a	ra		For	reman
	19a. Informant's Name/Relationship (Ty			19b. Ma	iling Address ((Street a	nd Numbe			r, City	or Town, State,	
	Clara Jones / S	'd at on		20%	Two alel.		***	77 - 3	omal abu		Marrilan.	1 21622
-	CLARA JOHES / S	oister	20b. F	Place of Dis	position (Name rematory or oth	yn B e of	ve.		Date Date		Mary lank ocation - City or	
	1 X Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)		10	-	-		1	04-1	3-2006	Ea	ston Mai	ryland
Γ	21. Sign dur of Funeral Service Licens	ее	, ,		22. Name and	Addres	s of Facilit	ty				
1	Mrsalla	Knin	de		426 D	e sn over	Str	rune eet.	ral Hom Easton	e .MA	ryland 2	21601
t	23a. Part1. Enter the disease, or compl	lications that cau	ed the deat	h. Do not e							- /	Approximate
	shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each	ude ,	und	Lilar	8,						Interval Between Onset and Death
	resulting in death)	a. Due to (or	s a consec	uence of):	1							cay
	O	CH	romic	Ken	al fai	Ture	/					years
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	บ้อย ใบ (จัก	as a consec	uerice of).	1							
	Cause (Disease or injury	. <i>171</i>	xbell	I M	Melitis	1						years
	resulting in death) Last	Due to (or	as a consec	uence of):								
		d										
_				-								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnan 9 □ Unknow	2 Feta t at time of c	al death	3 □Ectopic pre 5 □ Other (spe						23d. Date of de Month	elivery Day Year
1	Part II. Other significant conditions co	ntributing to deat	h hut not res	sulting in the	underlying co	use civo	n in Part I		23e. Did to	obacco	use contribute t	to the cause of death?
	Hypertense	tributing to deat		Juling III the	didenying oa				1 🗆 🗅			robably 4 Unknow
	Photoita								24a. Was	an	24b. Were a	utopsy findings availab
-	voer y								autop perfo 1 Tes	rmed? 2 12 N	death?	completion of cause o
ŀ	25. Was case referred to medical						26. Place	of Dea	th (Check only o	-	0 1 2 1 1	
ĺ	examiner?	Hospital: 1 ☐ Inp	atient 2	ER/Outpat	ient 3 DO	Othe	_ /				6 ☐Other (Spe	ecify)
1	27. Manner of Death	28a. Date of I (Month,		28b. Time		Bc. Injury Work		., saig i i	28d. Describe I			
	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injun	М		? ′es 2 🗌	No		,		
1	3 ☐ Suicide 6 ☐ Could not be	28e Plans of	Injury - At h	ome farm					28f. Location /5	Street a	and Number or R	Rural Route Number,
	4 Homicide determined	building	etc. (Speci	fy)	street, factory,	311100			City or Tov	vn, Sta	te)	
	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	rsician: To the be iner: On the basi and manner	s of examina	owledge, de ation and/or	eath occurred a investigation,	it the tim	e, date ar inion, dea	nd place, ith occur	and due to the red at the time,	cause(date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
-	29b. Signature and title of certifier	1. 1	2		29c.	License	number			29d. D	ate sign <i>ed (Mon</i>	th, Day, Year)
	•	Make	2011	P			DZ	593	53		4.6.06	
-	30. Name and address of person who o	ompleted cause	of death (Ite	m 23a) (Typ	e, Print)	_	-	<	/		C .	MA A.
	MICHAEL GROW	JLEY M	YD	GIC	DO.	ICH!	MAK	19	MANE		LASION	MD 2160
İ	31. Date filed (Month, Day, Year) APR 1 0 2008	7. Reg	istrar's Sign	ature	-							/
	APR 1 0 2008		w D		DAR							

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Lee Blades April 2006 Fairbanks 4:10 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mallard Bay Care Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 💢 F Yrs. 88 Director 1917 213-18-4633 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23e or 28e-f show 1 SYes 2 □ No Talbot Directo Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29345 Greenfield Ave. 21673 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "naturel', or 1 Yes 2 XNo Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ward clerk hospital 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumetic event 2008. Be Charles C. Blades Laura Horseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Rose Hill Place, Cambridge, MD Melvin G. Hickman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4/5/06 Maryland Veterans Cem! Hurlock, MD `4 □Donation 5 □ Other (Specify) 21. Signatur (of Funeral Service/Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD しかん 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final telvarred Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ NO 24a. Was an autopsy performed 1 ☐ Yes 2 No Hospitel or Attending Physicien: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P this 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Eunerel I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 576388 30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) Michael Fadden, M.D. Collien 02 kerlock md 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 12:56p M 30 Mary Evelyn Freeman March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge 8. Date of Birth
(Month, Day, Year)
March 4, 1919 Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 20XF Yrs. Director 87 216-56-1247 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28e-f show treumatic event, the Medical Examinar must be notified at 1 ☐ Yes XX No Maryland Dorchester Cambridge Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 100 Lee Drive US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Baltimore, Maryland 21215-0036 arphi1 Never Married 2 Married õ 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel", Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Menta! Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) J. Carroll Brannock Mary Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an ent: If item 27 is i Wilton K. Freeman Husband 100 Lee Drive Cambridge, Maryland 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State perrit. Pages Depirtment of Importent: If it any injury or o 1

☑ Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard 4/3/06 Church Creek, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** days resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, is a might be found or data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner consequence of a tract infection To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit unnar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident after death Director: in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ambridge MD 21613 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year FLETCHER **Physician** 2315 M MAR CHARIOTTE 291 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Yea Dec 11, 1 If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 32 LE **Funeral** Months Days Yrs 219-30-8658 90 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be rediffied at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State XXYes 2 □ No Anne Arundel Annapolis Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 Cedar Park Road 21401 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 2 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Librarian College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Yerbury 2 Frederick Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 405 Edlon Park Cambridge, Maryland 21613 Esther G. Jones P.R. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State Salisbury, Maryland 3/31/06 Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature # Funeral Service Licenses Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day detached for 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 800 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 2 No 1 Yes certificate 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ◀ 🗸 Inpatient 2 ER/Outpatient 3 DDA 2 this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28d. Describe how injury occurred Certification: After Injury Attending 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation after death Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 | Homicide ō To the Hospital o within 24 hours aff To the Funaral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print) 30. Name and address therson who ANNAPORIMD 1401 W 44 2006^{32. Reg} 31. Date filed (Month. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Manuel R. Fajota 2006 11:29 AM March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F 72 Yrs Director 576-38-0045 March 4, 1934 Philippines Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other then "neturel", or iteme 23a or 28e-f show other traumatic event, the Mudical Execution roust by motified at Maryland Arnold Anne Arundel 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 432 Wickliff Place 21012 U.S.A. Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 \$7 Yes 2 □ No If Yes, Give Year or Dates: 1955–85 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Senior Chief U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Victoriano Fajota Julita Ramirez P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Luisa Fajota/wife 432 Wickliff Place Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 5 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Arlington Nat. Cemetery 4/5/2006 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial **Physician** neus /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2M510m 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 Yes 2 No AB Hosper.
In 24 hours after deam.
The Funeral Director: After this centimes.
The Funeral Director of the funeral director, pt. Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29b. Signature and title. 29d. Date signed (Month, Day, Year) 00053393 DIO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1132 Odentan load oganna 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State APR 0 3 2006 Registrar

Physician	1					of Death		riograte, O O () 2345
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rector	U	219-54-1414 Isual Residence of Decedent	⊠ M 2□F	56 Yrs			Sep 1	3, 1949	MID
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r Iteme 23a or 28a-1 ei niner must be notified Funeral Director	1	Oe. Street and Number 11407 Morningsid	e Drive		10f. Zip Co	21502		10g. Citizen of Wha	
Examiner or Items Examiner or Items I by Fune		Marital Status Mever Married 2 Married Midowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S.	3. Was Decedent If Yes, specify	t of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
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d of e	יו	7. Father's Name (First, Middle, Last Durward B. Gra				Maryl	and M. (La	app) Graha	
Item 27 is marke other traumatic To	1	9a. Informant's Name/Relationship (Karen Graham	wife wife	19b. M	ailing Address (Si 407 Morr	rreet and Number or ningside D	Rural Route Numb rive Cumi	er, City or Town, Sta berland	"MD 21502
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page 2 should	-						24a. Was auto perio 1 Yes	ormed;? dea	re autopsy findings availa or to completion of cause of th? Yes 2
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mpletely fill	_	one)	miner: On the basis of and manner st	of examination and/o ated.	r investigation, in	my opinion, death o	ccurred at the time,		
S Co	12	29b. Signature and title of coatter	11			icense number		29d. Date signed (
		0. Name and address of person who	F 600	volume (Item 23a) (Ty		54004		APRIL 17	,2006
0,		SHIV KHANNA, M.D.				LAVALE, MD	21502		

		_ 1	For State Registrar	State of M	aryland	-	artment o			nd M		giene Reg. No.	006	12350
	Physicia /Medic	ın	1. Decedent's Name <i>(First, Middle, Last</i> William Dan	Gooi	n						2. Date of De Month April	Day	Year 006	3. Time of Death 9:05 P M
*6.	Examin	201	4a. Facility Name (If not institution, give Holy Cross Rehab	street and number, . & Nursi) ing Cen	iter	4b. City, To Bur	tons	vill	е			County of Deat	tgomery
×	Funeral Director			x 7. A	ge (In yrs. lasi 92	Yrs.	If Under 1 Months E		If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da Sept.	Year)		hplace (State or Foreign untry) ssachusetts
	h the Maryland or 28a-f show notified at		Usual Residence of Decedent 10a. State 10b. County Maryland Prince 10e. Street and Number	George's	10c. City, T	own or Lo	11e					10g. Citiz	en of What Co	10d. Inside City Limits 1 ☐ Yes 2 No untry?
036	be filed within 72 hours after death with the Maryland Hylgiene. Hylgiene do ther than "naturel", or Items 23s or 28s-f show event, the Madical Examiner must be notified at	by Fur	6912 17th Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 25 If Yes, Give Year or Dates:	? No			Cuban,	anic Orig	in? (Spe Puerto f	cify Yes or No Rican, etc.)		USA 4. Race - Ame Black, White Specify: As:	e, etc.
S	ad within 72 hc rgiene. Ior than "natul	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or		(Give life.	dent's Usual (kind of work DO NOT use Countai	done dui retired) nt	ring most			Acc		ndustry g/Federal
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked eny injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 【SCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature Principal Service Licens)	1	cem	polita	osition (Name matory or othe an Crema 2-Name and	er place) tory		April 20		Alex		, Virginia
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	רע		30. Name and address of person who a Dorothy Seay, M.			boov	Drive,	#20	5, S	ilve	r Spri	ng, N	4D 2070	8
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or 28	Director	10e. Street and Number	TT DO! D		10f. Zip Code 21 6	01		10g. Citizen	of What Coun	itry?
18 23a	Funeral	9560 GULLEYS COV	12. Was Decedent 1	Ever in U.S.	13. Was Decedent of	Hispanic Origin	? (Specify Yes or No	D- 14. R	Race - Americ	an Indian,
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mark	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. M	failing Address (Stree			er, City or Tox	wn, State, Zîp	Code)
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	_	Registrar Decedent's Name (First, Middle)	, Last)			rtificate				2. Date of Dea	_	Year_	3. Time of Death
ia: ica		William Geer								April	Day	2006	10:47 PM
ne		4a. Facility Name (If not institution,	-			4b. City, 7			of Death			nty of Death	
		Genesis Heal				If Under	Eas	ton	24 Hrs	O Data of Ries		Talbo	
		5. Social Security Number 182–24–4120	6. Sex 1 □ M 2 □ F	7. Age (In yrs. I		Months	Days	Hours	Min.	8. Date of Birti (Month, Day May 30,	1930	Coul	olace (State or Foreign ntry) Sylvania
	<u> </u>	Usual Residence of Decedent		10 00									
	.	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ပ္ဘ ⊢	Maryland Talbo	ot			Easto					10. Ohioo	414/2 -1 0	
1	2	10e. Street and Number 6611 Peachblos	agom Point	t Road		10f. Zip	2 1 60:	1			10g. Citizen d I	JSA	nuy?
	Funeral	11. Marital Status		edent Ever in U.	S. 13. V				iain? (Sp	ecity Yes or No-		ace - Americ	can Indian.
	틸	1 ☐ Never Married 2 Marri	ed 1 1 Yes	rces? 2 🗌 No					n, Puerto	ecity Yes or No- Rican, etc.)	В	lack, White,	etc.
	ል	3 Widowed 4 Divorced	If Yes, Giv Year or D	re ates:		1□Yes 2	No	Specify:			Spec	oity: Whi	te
	Completed	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	Occupa k done d	ition <i>Juring mos</i>	t of work	ing	16b. Kind of	Business/In	ndustry
•	E .	Elementary/Secondary (0-12)	College (1	I-4or 5+)	_	<i>DO NOT us</i> WYE T	e retired))			Legal		
		17. Father's Name (First, Middle, I	(act)		La	wyer		18 Moths	or's Name	e (First, Middle,			
	o Re	William John Ge								Jones			
	۲ ـ	19a. Informant's Name/Relationsh			19b. Mailir	na Address	(Street a	and Numbe	er or Rura	al Route Numbe	r. City or Tox	m, State, Ziu	o Code)
		Ruth Parker Ge								nt Rd.,	-		
	1	20a. Method of Disposition	_		lace of Dispo	sition (Nam	e of			Date	20c. Locatio		
		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (Sp		State	-			.	4/3	3/2006	Cambri	d∘e.	MD
		21. Signature of Funeral Service I	Licensee										
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ľ	1	231. Part1. Enter the dispase, or shock, or heart failure. List	complications that conly one cause on e	aused the death									Approximate Interval Between
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		resulting in death)	Due to	(or as a nsequ		-							
		Sequentially list conditions, if any, leading to immediate	b	,									
	lue	if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence ot):							6)	
	Examine	that initiated events resulting in death) Last	c	(or as a consequ	uence of):								
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:	Physician/Medical		0										
	Ž	IF FEMALE: 23b. Was decedent pregnant		come of pregna		7					23d. I	Date of deliv	ery
	Cla	in the past 12 months?	4□Pregr	oirth 2 Fetal nant at time of de		∃Ectopic pre ∃ Other (<i>sp</i> e						Month	Day Year
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	by P	Part II. Other significant condition	4	eath but not resi	ulting in the u	inderlying ca	iuse give	n in Part I					the cause of death?
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	Completed									24a. Was autop		prior to co	opsy findings available ompletion of cause of
	0.0									perfor 1 ☐ Yes	med? 2 No	death?	2 🗆 No
	Be	25. Was case referred to medical examiner?	11				0.1	-	of Deat	h (Check only o	ne)		
	2	1 ☐ Yes 2 No			ER/Outpatier			4 KNI		me 5 Resid			(y)
	ö	27. Manner of Death Natural 5 ☐ Pendin	9	of Injury th, Day Year)	28b. Time o	of 21	3c. Injury Work	rat ⟨? Yes 2. □		28d. Describe h	ow injury occ	Derrus	
	cat	2 Accident investig	not be and Blood	of Injury - At ho	ome fam et			.93 4	-	28f. Location /5	Street and Nu	mber or Run	al Route Number,
*	Certification:	4 ☐ Homicide determ		ing, etc. (Specify		. Set, lactory	, orno			City or Tow		11011	
	ن ا	29a. Certifier Certifyin	g Physician: To the	best of my kno	wledge, deat	h occurred a	at the tim	e, date ar	nd place.	and due to the	cause(s) and	manner as s	stated.
	edical		Examiner: On the b										
	Me	29b. Signature and title of certified	2	mD	1-	29c	License	number			29d. Date sig	-	-
			14	Hetro	W/ No	*		DI	1593	33	4	,30	5
					/				- , ,	-			
1	Ì	30. Name and address of person	who completed caus	se of death (Item	3a) (Type,	Print)	,	4		1	_	Do h	0
		30. Name and address of person	WEY M	se of death (Item	Dur	CHM	9N'S	LA	NE	E	1970N	MD	21601

Division of Vital Records, P.O. Box 68760,

William Geen

		1 - For State Registrar		State	of Maryla	ind / Depa	artmen rtificate			ind M		Reg. No.	16	12353
Physici		1. Decedent's Name (First, ARTHUR									2. Date of De. Month MARCH		Year	3. Time of Death
/Medio Examin		4a. Facility Name (If not ins			ımber)		· ·		Location o				ty of Death	· · · · · · · · · · · · · · · · · · ·
Funeral Director		5. Social Security Number 216–28–8367		ex 1 X M 2 □ F	7. Age (In yr 84	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Bird (Month, Da APRIL	y, Year)	Cou	place (State or Foreign intry) YLAND
rland 10 W		Usual Residence of Deced 10a. State 10b. 0	County		10c. (City, Town or Lo	cation				-			10d. Inside City Limits
ith the Marylan or 28e-f show	Director		UEEN .	ANNE		CENTRE								1 Tyes 2 XNo
with the	Dire	10e. Street and Number	.D. MTC	T DOAD			10f. Zip		7			10g. Citizen o		intry?
death ns 23	Funeral	212 SPANIAR	W NEC	12. Was Dec	edent Ever in	U.S. 13.	Was Deced	2161 lent of Hi		gin? (Spe	ecify Yes or No Rican, etc.)			ican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If time 27 is marked othar than "netural", or Itams 23e or 28e-f show eny injury or other traumatic event, the Medical Evantment or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other traumatic event or other event or o	by Fur	1 ☐ Never Married 2(Armed F 1 Yes If Yes, G Year or I	orces? 2 😿 No ive		fYes,spec 1 □ Yes		n, Mexican <i>Specify:</i>	, Puerto	Hican, etc.)		lack, White	
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uld be fill fental H rked oth	o Be	THOMAS GRE							ETHI		CRONSHA		a,	
d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Re	lationship (Турө, Print)		19b. Maili	ng Address	(Street a	ınd Numbe	r or Rura	I Route Numbe	er, City or Tou	m, State, Zi	ip Code)
1 and 1 and 1 am 27 ther tr		ANNA V. RII		ISTER	20b	212 D. Place of Dispo			NECK		D. CENT	REVILL 20c. Locatio		
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permi Depar Impor eny ir		1 /home	yt.	telfer	Men						S NEWNA CENTRE			OME, P.A. 1617
		23a. Pag 1. Enter the dise shock, or heart failur	ase, or com e. List only	plications that one cause on	caused the de	eath. Do not en	er the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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faw requires as been sign	ed b	Mullons	Pary	Higor	2 E)	MRSI	4	su	in		10	Yes 2000	3 Pro	babiy 4 □Unknown
stawre has be	Completed	Jessons	3/	Cecent	Spris	toll o	7 a	sper	atra		24a. Was autop		o. Were aul prior to c death?	topsy findings available ompletion of cause of
ician: The tav certificate has ector, page 2		preumor	nà		•						1 Tes	2 1 No		2□ No
ysician: is certific director,	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☐ Ho	medical	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 DC	Othe		1	me 5 ☐ Resi		other (Spec	ifv)
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l or Attending after death. Director: Afte	ertification:	O C Galerae	Could not b		e of Injury - A	t home, farm, st	M reet, factors		Yes 2 □	_			mber or Ru	ral Route Number,
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To the within 2 To the complet	Me	29b. Signature and title of	certifier				290	. License	number			29d. Date sig	ned (Month	, Day, Year)
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21/1/		30. Name and address of	person who	completed cau	ise of death (I	tem 23a) (Type, Voisling gnature	Print)	2,0	PA-	-	,	m	216	20
Sta	ate	31. Date filed (Month, Day	Year)	32.	Registra s Sig	gnature .	m	rue,	Cere	ocon	own,	- IV	-20.	
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	Physici	an	Decedent's Name (First,	Middle, Las								2. Date of D Month	Da		Year	3. Time of Deat	
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			Washington (5. Social Security Number	ounty 6. S			In yrs. last birth	day) If	Hage Under 1 Yea	rstor	der 24 Hrs.	R Date of B	irth		hingt	on lace (State or For	oian
	Funeral Director		213-12-7210		M 2□ F	92		M	onths Day			8. Date of B (Month, D June 3	ay Year	913	Cour	land	sigii
			Usual Residence of Decede	ent		12						ounc 3	0, 1	713	rial	/Land	
	ylanc how		10a. State 10b. C	ounty		1	0c. City, Town	or Locati	on						1	0d. Inside City Lin	nits
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	or 28	ire	10e. Street and Number					1	10f. Zip Code				10g. C	itizen of V	Vhat Cour	ntry?	
	th wi	al	16817 Longf	ellow	Court				217	740				U.	S.A.		
000	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If Health and Mental Hygiene. The stranger of the strang	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Div		12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2 X No ive	er in U.S.		Decedent of es, specify Cu			ecify Yes or N Rican, etc.)	lo-	Blac	e - Amend ck, White, ': White	etc.	
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<u>a</u>	should be nd Mental nmarked o	2	Samuel James	Grii	rith					C	arrie	E. Lap	ole				
ō	2 sho		19a. Informant's Name/Rel									al Route Num	-		State, Zip	Code)	
2	1 and 2 Health tem 27 other tr		Kathleen Gr	Lffith	n/Wife							lagerst	Ţ		2174		
5	ges 1 t of H if ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Crem	ation 3	Removal from	State	20b. Place of E cemetery,				1	Date	20c. l	ocation -	City or To	wn, State	
	ment: tent: jury		4 Donation 5 Ot	ner (Specify	y)		Boonsbo				4/8/		Boo	nsbo	ro,	MD	
0	permit. Pages 1 and Department of Healt Importent: if Item 2: any Injury or other 2		21. Signature of Funeral Se		1500			22. Na	ame and Add	ress of Fa	acility Re	st Have	en Fu	ıne ra	1 Ch	ape1	
	TOTEQ				m		- d					Ave., F		stow	m, M		
			23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final	se, or com. List only	one cause on	each line.	e death. Do no	ot enter th	ne mode of d	ying, such	as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death	
Ļ	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours attended. Within 24 hours attended att. To the Funstei Director, their this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to	(or as a c	consequence of):	rwoul	a							
O YOU O	t the death certific by the attending pached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			birth 2 (nant at tin	pregnancy Fetal death ne of death		topic pregnar her (specify)	су				23d. Dat Mo	e of delive	ory Day Year	Service Address
,	s tha		Part II. Other significant co				_	he under	rlying cause o	given in Pa	art I.	23e. Did	tobacco	use cont	ribute to th	e cause of death?)
SOLOS,	quire an sig	edt	congestiv	e h	eart	fail	ure					1□	Yes 2	P □ No	3 🗌 Prob	ably 4 Unkno	wn
	The law re te has bee age 2 sho	Completed by			~						·		opsy formed?	(leath?	psy findings availant pletion of cause	ble
Ö	ien: irtifice stor, p	BeC	25. Was case referred to mexaminer?	edical						26. P	lace of Deat	h (Check only			,		
>	nysic nis ce direc	To	1 Yes 2 No		Hospital:	Inpatient	2 ER/Outp	atient 3	3 DOA	ther: 4	Nursing Ho	me 5 Res	sidence	6 🗆 Oth	er (Specify	1)	
	tending Pt leath. lor: After th the funeral	ertification:	2 Accident	Pending nvestigation	1	nth, Day Y		ury 		∐Yes 2	2 □ No	28d. Describe					
<u> </u>	or At ifter of Direct in by	E		letermined	28e. Plac	e of Injury ding, etc. (- At home, fam Specify)	n, street,	factory, offic	0		28t. Location City or To	(Street a own, Stai	nd Numb (e)	er or Rura	Route Number,	
_	B Hospital 24 hours 2 B Funarel I etely filled	edical Ce	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Ph dical Exan	niner: On the b	e best of a	my knowledge, kamination and/	death oc	curred at the igation, in my	time, date	and place, death occur	and due to the red at the time	e cause(:), date ar	s) and ma	nner as st	ated. the cause(s)	
)	To the To the comp	Me	29b. Signature and title of c	i H	,				D		562		0			Dey, Year)	
	H		30. Name and address of p	erson who	completed cau	ise of deal	th (Item 23a) (T	ype, Prin	nt) MAI	HAV.	I Hu	BB LT,	MD		7		
	\		WASHINGTO					H	ngers	TOW	NW	ALYLA	+~D	21	140		_
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03-23-2006 VERLENE MAMIE GREENLEE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Temple Hills 1917 COLEBROOK DRIVE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Lumberton, N.C. 86 Yrs. 579-36-4339 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28s-1 show any Injury or other traumatic event, The Medical Experiment and other traumatic event, The Medical Experiment and other traumatic event, The Medical Experiment and other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Temple Hills Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20748 1917 Colebrook Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗗 No **Black** Specify: Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) +02 Elementary/Secondary (0-12) 12th Private Industry Certified Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Jones Junious Frank McAllister ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nedra Greenlee/daughter Temple Hills, Maryland 20748 2606 Fairlawn St. 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Lincoln Mem. Cemetery 03-30-06 20a. Method of Disposition 20c. Location - City or Town, State 12 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 mo1453 Cedar Hill FH Inc. 4111 Penn., Ave. Suitland, Md. Pan1. Enter the disease, or complications, or heart failure. List only one Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer Pancreas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physicien and thed for use as the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 this certificate has autopsy performe 1 ☐ Yes 2 💢 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical (Check only one) 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D15185 03/31/06 30. Name and address of person who completed cause n (Item 23a) (Type, Print) MD 1150 Varnum St. NE #104 Washington, D.C. 20017 E. McKnight John 32. Registrar's Sig APR 0 5 2006 State Registrar

ORIGINAL

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				State of M	arylan	-	rtment o				giene Reg. No.,	16	12356
			Decedent's Name (First, Middle, Last)							2. Dete of De	eth		3. Time of Death
	Physicia		LUCILLE G.	ARMANY						03-29-	-2008 -2006	Year	2:15 P.M.
7	/Medica Examine		4a Facility Name (If not institution, give s)			4b. C	ity, Town, or L	ocation of Deeth	4c. County	of Deeth	
Æ			FUTURE CARE PINEVI	EW NIRST	NG HO	ME.		CLI	ENTON		PRINC	E GEOI	RGE'S
	[®] Funeral		Social Security Number 6. Sex	7. Ag	ge (In yrs.	last birthday)	If Under 1 Y Months Da	ear If (Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da	th ly, Year)		ace (State or Foreign
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	and and	-	10a. Stete 10b. County		10c. Cit	y, Town or Loc	ation				-	10	d. Inside City Limits
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	h witi		9106 PineView Lane					2073	35			USA	
	deat	Funeral		2. Was Decedent Armed Forces?		S. 13. W	/as Decedent			pecify Yes or No Rican, etc.)		e - America	
2	or it		1 Never Married 2 Married	1 ☐ Yes 2√☐ If Yes, Give			☐ Yes 2 😾		ecify:	1 110011111		Blac	
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	and and in 27 in 27 in er tr	-	Claudia John/guard	ian					Rd. Car		,Md. 20		
Baltimore,	Pages 1 nent of H int: if iter iny or ott		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Re	emoval from State	C	lace of Dispos emetery, crem	atorv or other	place)	_ •	Date	20c. Locetion - Riverda		•
ᄩ	tmen tant: jury		4 ☐ Donetion 5 ☐ Other (Specify)		Kiv	verdale				4/3/06	Kiverda		
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		4	Mary Hedge			7							
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	Physician /Medical		Immediate Cause (Final	011	7								
	Examiner		disease or condition resulting in death) a.		Due to (o	ras a consequ	ieuce of).					1	
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Vital Record	law reas be	Completed										of de	pletion of cause eath?
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	ding F h. After funer		1 ☑Naturel 5 ☐ Pending	(Month, Da	y Year)	Injury		njury at Work? 1 ☐ Yes	2 🗆 No	200. Describe i	now injury occur	00	
Division	Attending ir death. octor: Afte by the fune	11Ca	3 ☐ Suicide 6 ☐ Could not be	28e. Piece of In							Street and Numb	er or Rural	Route Number,
ă	al or saftar saftar l Dire	Certification:	4 ☐ Homicide	building, et	c. (Specif)	v)				City or Tov	vn, Stete)		
			29a. Certifier 1 ✓ Certifying Physi (Check only 2 ☐ Medical Examine										
	the H in 24 the Ft	edical	one)	and manner st		aon and/or invi							
•	Vith Com	Σ	29b. Signature and title of certifier	2 04	ee c	hind		ense nur			29d. Date signe	(Month, D	ay, Year)
	XIA		Ol			1		0 21	-120	0	3/3	0126	200
	Bar		30. Name end address of person who con					: ייט דין זי	101 0	ז איייאד ד	MARYT.AN	m 207	35
	C.		ABULHASAN ANSARI, 31. Dete filed (Month, Day, Yeer)	MD 892	er's Siane	ture /	KUAD S	OTIE	. 101 (TINION,	MARYLAN	201	
	State	- X	APR 0.5 2006	Bearing	*	ture	,						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of N	/laryland		artmen <i>tificat</i>			ind Me		giene	'HIHA	238	57
	Physici /Medio		1. Decedent's Name (First, Middle, Lass Robert Leon Ga	assaway	, Jr.						2. Date of De Month MARCH	ath Day 30		3. Time of De 9:49A.	ath M
	Examir	er	4a. Facifity Name (If not institution, give #5 BRIDGEWELL PKW	Y			ELK	CON	Location of			CE	County of Deat		
	Funeral Director		5. Social Security Number 221-22-7031 6. Se	x	Age (In yrs. la 69	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Da 0 7 / 2	1 / 1	9. Birt 936Mar	hplace (State or Fi unity) Yland	oreign
	a-f ahow	ctor	10a. State 10b. County MD Cecil			, Town or Lo kton	cation							10d. Inside City L	
	ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number #5 Bridgewell I	Pkwy.			10f. Zip 219					10g. Citi US	zen of What Co	untry?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural', or items 23s or 28s-f show any figury or other traumatic avant, if a Musical Examinat must be notified at ance.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Deceder Armed Force: 1 [XYes 2 [If Yes, Give Year or Dates	s?]No	, 1	Vas Deced Yes, spec	offy Cubar	spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: B1	etc.	
21215-0036	d within 72 h giene. er then "netu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) Colfege (1-4o	r 5+)	16a. Deced (Give life. L Engi	kind of wo OO NOT us	rk done di se retired)	tion uring most	of workin	g	- 17	os of	^{ndustry} Enginee	rs
Maryland	should be file ind Mental Hy, a marked othe umatic avant,	To Be C	17. Father's Name (First, Middle, Last) Robert L. Gass		Sr.				Eve	lyn	(First, Middle, Gibbs		·		
, Mar	and 2 sho ealth and m 27 is m	1 10	19a. Informant's Name/Relationship (7) Robert Sorden	vpe, Print)		18 CI	into	on C	nd Number E. Ne	ew C	castle	, D	Town, State, 2 E 1972	0 	
Baltimore,	t. Pages 1 rtment of H rtant: if ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,		Boh	ace of Dispo metery, cren CM1a	Mánc	ther place T		/8/2		hesa		City,	MD
Bal	Dermi Depa Impo		21. Sign fulle of Funeral Service Lice	MM M	Lic # 00860	20	1 N.	Gra	ay A	ve.	Wilm,	DE	L HOME 19805	A	
	Physician /Medical		23a. Part . Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Hyper		atheros					disease			Approximate Interval Betwee Onset and Dea	
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P.O. Box (The law requires that the death certificate be executed ite has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetaf	death 3	Ectopic pro Other (sp.					2	3d. Date of deli Month	very Day Year	r
	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death	but not resul	lting in the ur	derlying ca	ause give	n in Part I.			obacco u /es 2[the cause of deat	
al Reco	ician: The law re certificate has bee rector, page 2 sho	Completed											24b. Were au prior to death? 1 DYYes	topsy findings avaitompfetion of cause	lable e of
Division of Vital Records,	ding Phys n. After this funeral di	atlon: To Be	25. Was case referred to medicaf examiner? 1 N Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpa 28a. Date of In (Month, D		R/Outpatient 28b. Time of Injury		A Other	. 4 🗆 Nur	sing Hom	(Check only o	dence 6	Other (Spec	uty) SCENE	
Divis	tai or Attensis after deati al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At hon etc. (Specify)	me, farm, stre	eet, factory	, office		28	Bf. Location (S City or Tow	Street and vn, State)	Number or Ru	ral Route Number,	,
	To the Hospital within 24 hours or To the Funeral completely filled	edicai	29a. Certifier 1☐ Certifying Phy (Check only one) 1☐ Medical Exami	sician: To the bes ner: On the basis and manner:	of examination	vledge, death on and/or inv	occurred a estigation,	at the time in my opi	e, date and nion, death	place, ar h occurred	nd due to the d d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	with To corr	₹.	29b. Signature and title of certifier Will Wil	half, na)		290	O.C	number .M.E.				signed <i>(Montt</i> H 31, 20		
	2		Pamela E South					ENN :	STREE	T BAI			ARYLAND		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2006	2. Regis	trar's Signatu	Tre Span	W								

			For State Registrar	State of		d / Depa		t of H	ealth a		ental Hy		06	12358
			Decedent's Name (First, Middle, Last	')	·						2. Date of De			3. Time of Death
	Physici	an			3535337	TT.	AGE A D D				Month April	Day 13,	Year 2006	10:24 P M
	/Medic		4a. Facility Name (If not institution, give		EWEY		OWARD		Location o	of Death	ADLII		unty of Death	110:24 P
	Examin	er					40. City, 1					40.00	Somer	cot
			McCready Memorial 5. Social Security Number 6. Se		.a⊥ . Age <i>(In yr</i> s.	last hirthday	If Under		risfi fUnder:	24 Hrs	8. Date of Birt	b		
	Funeral			X ZM 2□F ′		Vro	Months	Days	Hours	Min.	January	y, Year)	Coul	place (State or Foreign
	Director		219-46-4581 Usual Residence of Decedent		57						January	20, 19	19 Mary	land
	and *		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							IOd. Inside City Limits
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	r de lems	ıne	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Deced If Yes, spec	ent of Hi rfy Cuba	spanic Orig n, Mexican	gin? (Spe ı, Puerto	cify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
36	or it	YF	1 ☐ Never Married 2 ☐ Married	1 XYes 2 If Yes, Give			1 ☐ Yes 2	No	Specify:			Sp	ecity: Whi	.te
Š	J within 72 hours after death with the Maryland jiane. I than Instural; or items 23a or 28a-f ahow Its Musical Examirer must be mulified at	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dat	es:									
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7	within iene. than "I	ημ	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT us						ctional	-
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nd		Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Su	тате)	
/la		2	William Franklin	loward					Ruth	H. 1	Landon			
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (T	ype, Print)			-				I Route Numbe	-		
	1 and 2 Health (lem 27 i		Ruth H. Landon Hor	ward (Mo	other)	268	Somer	s Co	ove Ap	partı	ments -	Cris	field,	MD 21817
ā,	of Healt item 2		20a. Method of Disposition		20b. F	Place of Dispo	osition (Nam	ne of	e)		ate	20c. Locat	ion - City or To	own, State
20	A - = =		1 ☐ Burial 2 🔯 Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify)		ate					7	E 2000	Salisk	oury. N	Maryland
			21. Signature of Funeral Spice Lie	- A	1361		2. Name and				5, 200	Darrio	oury, .	ial y land
Ba	permit. Departr Imports any inju		1110WBULK	SIGUIN	wy	WH I	Bradsh	aw 8	Sons	s Fu	neral H	lome		
			Mary Beth Bra			b Do not on	306 W.	Ma	in St	reet	- Cris	field	, MD 21	Approximate
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on ea	ch line	n. Do not en	ter the mode	e or dying	y, such as	cardiac	i respiratory ai	rrest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a	Han	E My	etur) 4	al.	Sufar	Lw				Onoci and Dodan
	/Medical		resulting in death)	Due to (o	r as a conseq	uence of):	II ALS	6	- 4					
	Examiner		Sequentially list conditions	b	Coro	many f	Hitsay	Dur	ese					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a conseq	uence of):								
V	cutec	Examiner	that initiated events	C	Hy	fert Eu	non							
ó	exector and and rial-ti	EX	resulting in death) Last	Due to (o	r as a conseq	vence of):	1	- N	1.116	b				
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial transit	cai	(d	ly	pe I.	nosel	er 1	12000	45				
68	ificat g ph) as th			5										
Вох	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-					23d	. Date of deliv	ery
ă	eath atte	cial	in the past 12 months? 1 ☐ Yes 2 ☐ No		th 2∏Feta nt at time of d		_Ectopic pre ☐ Other (spe						Month	Day Year
O.	at the de by the a tached	iysi	9 Unknown	9□ Unknov	vn			.,						
٩	that ed by deta	F.	Part II. Dther significant conditions co	ntributing to dea	ath but not res	ulting in the u	inderlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to t	he cause of death?
S	ires sign d be	l by									†□'	Yes QAN	lo 3 ☐ Prot	pably 4 Unknown
Records,	w requir been si should	Completed												
ec	e law has t	npl									24a. Was autor	DSV	prior to co	opsy findings available impletion of cause of
<u> </u>		Son									1 Yes	2 No	death? 1 ☐ Yes	2□ No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	12.35					26. Place	of Death	(Check only o	one)		
>	ysician: iis certific director,	To	1X Yes 2 □ No	Hospital: 1 🔲 In	patient 2	ER/Outpatie	nt 3 DO	A Othe	9r: 4 🗆 Nu	rsing Ho	ne 5 🗆 Resi	dence 6 [Other (Specia	(y)
ı of	g Ph er th seral		27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time o	of 28	8c. Injury Work			28d. Describe l			
Ö	nding P Mh. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	pwornin	, Day roar)	jury	М		Yes 2 □ I	No				
Division	or Attending after death. Director: After in by the fune	iţici	3 ☐ Suicide 6 ☐ Could not be determined	200. Place (of Injury - At h		reet, factory	, office					lumber or Run	al Route Number,
Ö	- i te	Certification:	4 Homicide	Duligin	g, etc. (Specif	<i>y</i> /					City or Tox	wii, State)		
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier Certifying Phy	/sician: To the t	est of my kno	wledge, deat	h occurred a	at the tim	ne, date an	d place,	and due to the	cause(s) an	d manner as s	stated.
	24 to 5 Fu	Medical	(Check only 2 Medical Examone)	iner: On the bas and manne	sis of examina	ition and/or in	vestigation,	in my of	oinion, dea	th occurr	ed at the time,	date and pla	ace, and due t	o the cause(s)
	o thin	Me	29b. Signature and title of certifier		-		29c	License	number			29d. Date s	igned (Month,	Day, Year)
	⊢ ≯ ⊢ ŏ		W/-	MM the				ъ.	15715			Anvi	1 15, 2	2006
	0-		, , , ,	, ,			-	D	TOITO	· Salit	10,01,011	APL I	T T21 4	
,	り		30. Name and address of person who o											
			William Gill,				n Aver	nue ·	- Cri	sfie	ld, MD	21817		
		ate	31. Date filed (Month, Day, Year)		gistrar's Signa	ature	9							
	Regist	rar	APR 1 9 2	UU5	Coppe .	S. A	2345							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State o	f Marylan		artment of			ental Hy	giene Reg. Np. 0	6	123	59
			Decedent's Name (First, Midd	le, Last)						2. Date of De	eath	Va	3. Time o	of Death
	Physici /Medio		Alfred G. Huber	c						April	4, 2006	Year	8:15	Ам
	Examin		4a. Facility Name (If not institution	-			4b. City, Town				4c. County			
			Wilson Health (Gaithe				Mont	_	,	
U	Funeral Director		5. Social Security Number 217–30–0470	6. Sex 1≹ M 2 ☐ F	7. Age (In yrs.	9 Yrs.	Months Day		Min.	8. Date of Bit (Month, Da April	13,1936	9. Birthr Cour Mary	place (State of http:) Land	or Foreign
	pur &		Usual Residence of Decedent 10a, State 10b, County	,	10c Cit	v. Town or Lo	cation						IOd. Inside C	Shy Limite
	Maryl: f sho	ror		gomery		ithers								2 No
	r 28e	irec	10e. Street and Number				10f. Zip Code				10g. Citizen of V	What Cour	ntry?	
	th wit	aD	407 Russell Ave	enue, #501			2087	7			United S	State	s	
36	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-1 show eny injury og other traumatic event, the Medical Examinations in cilified at one.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ried Armed Fo	2□No 19: ve	54	Was Decedent of I Yes, specify Cu I ☐ Yes 2 🕱 N	ıban, Mexicar	n, Puerto F	cify Yes or No Rican, etc.)	Blac	e - Americk, White,		
Š	2 hou	ted	15. Deceder	nt's Education	4100.	16a. Deced	dent's Usual Occ	upation			16b. Kind of Bu			
21215-0036	f within 7 liene. r than "n	Completed	(Specify only higher Elementary/Secondary (0-12)	College (: 5+	1-4or 5+)		kind of work don DO NOT use retii tor of]			ng	Departr Comme		of	
힏	al Hyg other	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle	, Maiden Suman			
<u>X</u> a	Menta Menta arked aric e	To	Gottlieb Huber					Gis		Graf				
Maryland	nd 2 sh alth and 27 is m ir traum		19a. Informant's Name/Relation: Cynthia H. Cohr		r						er, City or Town, Califor			
altimore,	of Her		20a. Method of Disposition 1 □ Burial 2 ▼Cremation	2 □ Bomoval from	20b. P	Place of Dispo	sition (Name of	lace)	pril	ate 7	20c. Location -			
Ĕ	ment ant: I		`4 □ Donation 5 □ Other (S				ium, Inc		200		Alexand	ria,	Virgi	nia
Ball	permit Depart Import eny in		21. Signature of Funeral S		MQ0689		Name and Add		DC		neral Hoburg, Ma			
			23a. Rant 1 Enter the disease, o	r complications that of	aused the deat								Approximati	te tween
	Physician	i ji	Immediate Cause Final disease or condition	Me	tast	atic	acre			4		li c	Spiset and	Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	uence of):	1 1			2.12	ma			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	levi (or as a conseq	uence of):	acco	CIN	KC	lu	nej			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S .							1			
Ō,	cate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to	(or as a conseq	uence of):								
8760	ate by	dlcal		d										
Вох 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnan	cv				e of delive		
o.	t the dea by the at ached fo	hysicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregr 9□Unkn	nant at time of d	eath 5□	Other (specify)				Mod	ntn	Day '	Year
S,	es thai gned b	by P	Part II. Other significant conditi	ons contributing to de	eath but not res	ulting in the ur	nderlying cause o	iven in Part I.		23e. Did t	obacco use contr			
ord	w require been si should t	ted	Dreum	mea	teap	-cree-	conj	quel	cc LC	12	Yes 2 □ No	3 Prob	ably 4 □l	Jnknown
Records,	e law i has b	Completed	Multipl	usele	2130	X 1	Let ye	Miss	200	24a. Was	osy /	Vere auto prior to cor leath?	psy findings npletion of c	available ause of
g			25. Was dose referred to medica	riden.	cki	4-2	em	1		1 Tes	2 No 1	Yes	2□ No	
5	ysicia is certi directo	o Be	examiner?	Hospital:	npatient 2 🗆	ER/Outpatien	t 3 DOA			(Check only o	one) dence 6 ⊡Othe	ar (Specifi	4)	
0	ding Phy h. After thii funeral c	1	27. Manner of Death	28a. Date		28b. Time of Injury	28c. Inj		-		how injury occurr		*/	
Sion	endin eath. or: Af	atlo	2 1 100100111	igation	, Day . oa.,	,,		⊒Yes 2□	No					
Division of Vital	el or Attending P s after death. il Director: After id in by the funer	Certification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place	of Injury - At ho ng, etc. (Specif	ome, farm, stre	eet, factory, office	9	2	8f. Location (S City or Tov	Street and Number vn, State)	er or Rura	l Route Num	ber,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	edical (29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the Examiner: On the b	best of my kno asis of examina ner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and opinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s	:)
	To th within To th	Me	29b. Signature and title of certifie	ər		/	29c. Licer	nse number			29d. Date signed	(Month,	Day, Year)	
)	18+1		1/4 Rales	rton	sch	and	us DO	4115			April	14,	200	4
		9	30. Name and address of person H. Robert Birse	who completed caus	e of death (Item	23a) (Type,		ue, Ga:	ither		V			
	Sta Registr	-	31. Date filed (Month, Day, Year,	5 2006 32.	egistrar's Signa	in de	artis							

			1 - For Stete Registrar	State of Maryla		artment rtificate			nd M		giene Reg. No.	6	2360
I	Physici	an	1. Decedent's Name (First, Middle, Las	•						2. Date of Dea	ath Day	Year,	3. Time of Death
	/Medi	cal	Gloria Lorra			4. 01. 3			5	April	6.	2006	4.45 P M
	Examir	ier	4a. Facility Name (If not institution, give	11.	ome			boro	Death			hing	2)/0
	Funeral		5. Social Security Number 6. S	x 7. Age (In yr.	s. last birthday)	If Under	1 Year	If Under 24		8. Date of Birtl (Month, Day		9. Birtho	lace (State or Foreign
	Director		171-28-5618	□M 2 X F 9	1 Yrs.	Months	Days	Hours	Min.	Month, Day March 6		Coun	yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c (City, Town or Lo	reation							0d. Inside City Limits
	Maryli f sho	ō	Maryland Washing		-	nsboro	_					'	1 ☐ Yes 2X No
	r 28e	Director	10e. Street and Number	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10f. Zip					10g. Citizen o	f What Coun	itry?
	th with	ai D	8507 Maplevill	e Road			2	1713			U	.S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decede	ent of His	spanic Origin	n? (Sper Puerto F	cify Yes or No- Rican, etc.)	14. Ra	ace - Americ ack, White,	
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ※Divorced	Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give	ł	1 ☐ Yes 2		Specify:			Spec		nite
21215-0036	72 hours after death with the Maryland neturel', or Items 23a or 28e-f show disal Examinat must be rodified at		15. Decedent's Ed	Year or Dates:	16a, Dece	dent's Usual	I Occupa	tion	-		16b. Kind of		
215	within 7% ene. than "ne	piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of worl DO NOT us	k done d e retired)	uring most o	of workin	g	TOB. TAILE OF	043/11033/1110	Justry
21	e filed within al Hygiene. other than vent, the My	Completed	12		Sa	les Re	ep				Cl	othing	g Mfg.
ind	be fill hall Hy d oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle,		,	
Maryland	should nd Men marke umatic	ပ	Franklin A. Wel		10h Maille	- Add	(C)			elle Mi			
Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23s or 28e-f show any injury or other treumatic event, the Mudical Examinat must be notified at ance.		Cynthia Ann Hir		101					Route Numbe			
ē,	s 1 ar		20a. Method of Disposition	20b.	Place of Dispo	sition (Nam	e of			Hagers	20c. Location		id 21742 wn, State
E	Pages nent of int: If ii		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		Rose Hi				-10-	-2006	Hager	stown	Maryland
Baltimore,	Departm Departm Importar any inju		21. Signature of Funeral Service Licen.	see 7	22	2. Name and	d Address	s of Facility	Doug	alas A.	Fierv	Fuenr	al Home
_	2012		/ Danglors	1 tury	1,	331 Ea	<u>ıster</u>	n Blv	d. N	V. Hage	rstown	Maryl	and 21742
			23a. Part1. Enter the disease, or comp shock, or heart allure. List only	ne cause on each line.					-				Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. lecal i	mass	wil	h p	cofold	alv	10			onot and boats
ı	Examiner			a. Cecal) Due to (or as a conse	equence of):	wa	Dan	tine	nl	abrece	11		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of);	4,							
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	V	slyte	emb	alc	nce					
8760,	cate be executed physician and the burial-transit	al Ex	resulting in death, cast	Due to (or as a conse	equence of):	nart	10	Lish	0~				
687	icate physi s the l	Physician/Medical	•	d	any 10	will	"						-
Box	n certii nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg							23d. D	ate of delive	rv
m .	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pre Other (s <i>pe</i>					M	onth	Day Year
P.O.	res that the death certific igned by the attending p be detached for use as	Phys	9 Unknown										
	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as:	by	Part II. Other significant conditions co	intributing to death but not re	sulting in the u	nderlying ca	use giver	n in Part I.				ntribute to th	e cause of death?
000	w requir been si should	etec											
Vital Records,	he lay	Completed								24a. Was a autops perform	sy	prior to con death?	ssy findings available pletion of cause of
ta	an: T tifficat tor, pa	0	25. Was case referred to medical					26 Place of	f Death	↑ 1 ☐ Yes :	2 1 No	1 🗆 Yes	2 □ No
	nysici	To B	examiner?	Hospital: 1 🗍 Inpatient 2 [☐ ER/Outpatien	t 3 🗆 DOA	Other	-		e 5 Reside		her (Specify)
0	ing Pt ofter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury Work			Bd. Describe h			
<u>s</u>	Attending Physician: r death. ector: After this certific. by the funeral director,	icati	2 Accident investigation 3 Suicide 6 Could not be	200 Bloom of Injury At	homo (a	M		es 2□No		96 Lacation (C			
Division of	i or A after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, ractory,	onice		2	City or Town	n, State)	oer or Hurai	Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: Attenthis certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sicien: To the best of my kr	nowledge, death	occurred a	t the time	, date and p	olace, ar	nd due to the ca	ause(s) and m	anner as sta	ated.
	the Ho in 24 the Fu	edicai	(Check only 2 Medical Exem	iner: On the basis of examinand manner stated.	ation and/or inv	estigation, i	in my opi	nion, death o	occurre	d at the time, d	ate and place	and due to	the cause(s)
	Vith Common	Σ	29b. Signature and title by certifier	1. (License		2		9d. Date sign		-
,			1	7/00		U	006	2223	3		4/7/	06.	
عاث	1-1		30. Name and address of phrson who c	ompleted cause of death (Ite 7 LUM, MD 32. Registrar's Sign	340 Type, 1	Print)	TRE	et t	HAC	(RITO6	IN MI	0 - 2	1740.
	Sta	te	31. Date filed (Month Pay Year) 2	32. Rygistrar's Sign	nature	/							
	Registr	ar	AFR U 1 Z	UUO Aleen	13. 19	series.							

Harman Glond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** EMMA VIRGINIA HIGDON MARCH 28 2006 12:50 A^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 32061 TUCKAHOE AVENUE CORDOVA **TALBOT** If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 X F Director 220-32-8203 79 MAY 9, 1926 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f show traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32061 TUCKAHOE AVENUE 21625 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ģ Specify: WHITE 3 ▼ Widowed 4 □ Divorced 'natural' Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygiens Important: If Itam 27 is marked other the any injury or other traumatic avant. HOMEMAKER 11 OWN HOME -0-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELI SMITH LYDIA BICKLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVEN A. HIGDON/ SON P.O. BOX 22, HILLSBORO, MD 21641 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State CHESTERFIELD CEMETERY 3-31-2006 CENTREVILLE, MD 21617 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fa 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part. Enter the disease, or complications that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

ADDROXIS Immediate Cause (Final disease or condition resulting in death) Physician MALIGNAN CV /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit 1406/65 Due to (or as a consequence of) physician Physician/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 certificate has 1 Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After t Certification: 1 Natural 2 Accident 5 Pending investigation Injury death. 1 Tes Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funaral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 106 , W. (1 027055

Box 68760,

P.0.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOEL H. WILKERSON, M.D., 204 MEDICAL CENTER RD., GRASONVILLE, MD 21638

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

			for State Registrar		State of	of Mary			tmen				lental Hy		DITE	15	12362)
	¥		Decedent's Name (First,	Middle, Last	t)				777041				2. Date of De			ut light	3. Time of Death	_
	Physici Medio		JOHN RUSSELL	HILL									APRIL	3 2	006	Year	7:31 am ^M	A
	Examir	ner	4a. Facility Name (If not inst CIVISTA MED			ımber)			LA F	LAT.	A	ion of Death			CHAR	y of Death		
	Funeral Director		5. Social Security Number 213–88–5887		x 2 M 2□F	7. Age (In 43	yrs. last birth Y		If Under Months	1 Year Days	If Ur Hou	ors Min.	8. Date of Bir Month, Da MAY 10	$\stackrel{\text{rth}}{,}\stackrel{Y_{\theta}}{1}\stackrel{\text{a}_{y}}{5}$	62	(:01	place (State or Foreig intry) IINGTON, DC	
	land ow		Usual Residence of Deceder 10a. State 10b. C			100	c. City, Town	or Loca	ation			·····					10d. Inside City Limits	s
	Mary e-f sh	tor	MARYLAND CI	HARLES	3	N	EWBURG	,									1 Tyes 2 No	0
	or 28	Dire	10e. Street and Number						10f. Zip					10g. C	itizen of	What Cou	intry?	
	eath v	Funeral Director	15180 ROCK PO		12. Was Dec	edent Ever	2 11 ni	13 W		2066		Origin? (Cn	ecify Yes or No			STAT	ES ican Indian,	
ဟ	after d	Fun	1 Never Married 2		Armed Fe 1 ☐ Yes	orces? 2 X No	#1 U.S.	If Y	res, spec	ify Cuba	an, Mex	cican, Puerto	Rican, etc.)	,	Bla	ck, White	, etc.	
003	iours a	d by	3 Widowed 4 Div	orced	If Yes, Gi Year or D			11.	JYes 2	2L X No	Spe	city:			Specif	BLA	CK	
/ 215-0036	within 72 hours after death with the Maryland ene. hen "natural", or Items 23e or 28e-f show he Medical Examinar must be notified at	iete	(Specify only		ication le completed))	16a. I	Decede Give kil	nt's Usua nd of wor	l Occup	during	most of work	ing	16b. ł	(ind of B	usiness/lr	ndustry	
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In	be file tal Hy d othe	Bec	17. Father's Name (First, M.						•		18. M	other's Nam	e (First, Middle	, Maidei	n Suman	пе)		
<u> </u>	hould d Men marke	5	JOHN BRUCE H		una Print)		106	Mailia	Address				ESTINE (_
Z Z	nd 2 salth an 27 is r		BRUCE HILL /					-					5, WASH				20020	
John Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Importantent of Heatth and Mental Hygiene with a transmission of Heatth and Mental Hygiene was transmissed of the without and the master and the master of show eny injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition 1 XBurial 2 ☐ Crema				Ob. Place of I	Disposit	tion (Nam	e of		and the same of th	Date			_	own, State	
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8			23a. Part1. Enter the disea shock, or heart failure	se, or compl	lications that	caused the	death. Do no	ot enter	tne mode	of dyin	ng, such	n as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death	
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		a. EN	DS1	MGE	11	ve	~	CI	rrk	10515				Oriset and Death	
	Examiner		Due to (or as a consequence of): Rewal Falure															
	₽ ≓	ner	if any, leading to immediate Due to (or as a consequence of):															
	i be executed sicien and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last		c. Pue to	(or as a cor	I Pa	to	~4	tr	410	ure						
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Вох	eath certif attending for use a	lan/N	IF FEMALE: 23b. Was decedent pregnal in the past 12 months?	II.		birth 2 🔲 l	Fetal death	3 □E	ctopic pre	gnancy	,					te of deliv	ery Day Year	
P.O. I	at the dea by the a tached f	ysic	1 Yes 2 No		4□ Pregr 9□ Unkn	nant at time lown	of death	5 🗆 C	Other (spe	ecify)					NIO	ATTE !	Day 16a1	
م.	The law requires that the death certifiate has been signed by the attending bage 2 should be detached for use as	by Physician/M	Part II. Other significant co	nditions cor	ntributing to d	leath but not	t resulting in	the und	erlying ca	iuse giv	en in P	art I.	23e. Did t	obacco	use cont	tribute to t	he cause of death?	
ords	v require been sig should b		ISOPHA.	gea	10	4RI	ces	<u>-</u>					10	Yes 2	No	3 🗆 Prol	bably 4 Unknown	1
ec	e law r has be e 2 sh	Completed	HEPATI	415									24a. Was	osy	24b.	Were auto	opsy findings available empletion of cause of	в
<u>la</u>	ician: The lav certificate has ector, page 2 a		05 111-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-										1 ☐ Yes	2/2 No		death?	2□ No	
Division of Vital Records,	Attending Physician: r death. ector: Atter this certifica by the funeral director, p	o Be	25. Was case referred to me examiner? 1 Tyes 2 No	_	Hospital: 1	Inpatient	2 ER/Outp	patient	3□ DO	Oth	00	The state of	n <i>Check</i> o <i>nl</i> o		6 □Oth	er (Speci	60	-
0	ding Ph J. After th funeral	on: T	27. Manner of Death 1. Natural 5 □ P	ending	28a. Date		28b. Tir			Bc. Injun			28d. Describe I				7/	
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-	21		30. Name and address of pe		6													
	Sta	te	31. Date filed (Month, Day,	FERSO Year)	32. H	lecistrar's 5	ignature				WAL	DORF N	IARYLANI	20	601			
- 1	Registr		ADD	05:	วกกร์ 🎝	11:014	· K	40	and.	,								

			For State Registrar	State of M	laryland / D	-	t of Health e <i>of Deat</i>		lental Hy	giene Reg. No.	006	12363
	Physicia	ın	1. Decedent's Name (First, Middle, Last						2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic Examin		Dorothy Mae 4a. Facility Name (If not institution, give	Johns street and number,)	4b. City,	Town, or Location		April	2 4c.	2006 County of Deat	5:30 AM ^M
	ZAGITITI		Genesis HealthCa	are - Th	ne Pines	5	Easton				Talbo	t
	Funeral		5. Social Security Number 6. Se	x 7. A	ge (In yrs. last birth	Months	1 Year If Under	er 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt	hplace (State or Foreign untry)
	Director		218-16-6966 Usual Residence of Decedent	3 ···· 224 ·	81 ^Y	rs.			09-09-		l	land
	yland now		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	a Har	to	Maryland Talbot		East	on						1. Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip	Code			10g. Citiz	en of What Co	untry?
	s 23a	rai	610 Dutchman's				1601				USA	
II.	Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 🛣	?	13. Was Dece	dent of Hispanic (cify Cuban, Mexic	Origin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	p- 1	 Race - Ame Black, White 	
920	urs af	ρ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	140	1 ☐ Yes	2. No Specii	fy:			Specify:	lack
ns 21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. kther then "naturel", or Items 23a or 28a-f show ant. The Medical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. [Decedent's Usua	al Occupation	net of work	ing	16b. Kir	d of Business/	
2	ithin ne.	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT u	rk done during m se retired)	USE OF WORK	ng .			
Johns and 212	iled w Hygier ther ti nt. In		12 17. Father's Name (First, Middle, Last)		(Cafeter	ia Manag		e (First, Middle			Co. School
Jo	d be i	o Be		D						, Maidell	ourname)	
thy Joh Maryland	should ind Men marke	၉	Fred 19a. Informant's Name/Relationship (7)	Brumme11 pe, Print)	19b. i	Mailing Address	(Street and Num	mma.] ber or Rura		er, City or	Town, State, 2	lip Code)
	and 2 ealth a n 27 ls	ì	Dorothy Johns / I	aughter	20	5 Wriel	tson Av	. F	aeton M	arv1	no.1 216	01
Dorothy Baltimore, Mar	of H of H if Iter		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	Removal from State	20b. Place of L	Disposition (Nar., crematory or c	ne of	,	Date	20c. Loc	ation - City or	Town, State
D D	Pages ment of I		* 4 ☐ Donation 5 ☐ Other (Specify)			terans	Cem.	04-0	6-2006	Hur.	lock, Ma	ryland
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	99	()	22. Name ar Benni	d Address of Fac e Smith	rility				
	402 % 4		23a. Part 1. Enter the disease, or compl	Cons	diba doorb Door	516 8	e Smith . Main	Street	t,Hurlo	ck, Ma	aryland	
		Ì	shock, or heart failure. List only of	ne cause on each I	ine.				or respiratory a	rrest,		Approximate Interval Between Onset and Death
9	/Medical		disease or condition resulting in death)	a	eveb NOV		accia	ent				goars
	Examiner			Due to (of as	in next en	The state of the s						14045
		ner	Sequentially list conditions, lary lead to the cause. Enter Underlying Cause (Disease or injury	Due to (or a	consequence of			-				J
	acutec ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	herosde	105/3						years
8760,	cate be executed physician and the burial-transit	Ě	resulting in death) Last	Due to or as	a consequence of):						
387	physi s the b	dical		d.								
Box (eath certifi attending I for use as	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome						2	3d. Date of deli	verv
B.	death e atter	Physician/Me	in the past 12 months?	4 Pregnant a	2 □Fetal death t time of death	3 □Ectopic pr 5 □ Other (sp					Month	Day Year
P.0	at the de by the	hys	9 ☐ Unknown	9□ Unknown								
	es that igned b	by P	Part II. Other significant conditions con	ntributing to death b	out not resulting in t	he underlying c	ause given in Par	t I.				the cause of death?
ord	w require been sign	ted							1 🗆	Yes 2□]No 3∏Pro	obably 4 Unknown
ec	2 2 2	ompieted							24a. Was autoj	psy	prior to d	topsy findings available ompletion of cause of
a F	riclan: The certificate ha rector, page	O !							1 ☐ Yes	2 No	death?	2 No
V.	Physiclan: this certificanal director,	o Be	25. Was case referred to medical examiner?	lospital:			Other		(Check only o	-		
of	Phys er this eral dii	- 1	1 Yes 2 No	28a. Date of Inju	ıry 28b. Tir	ne of 2	8c. Injury at		me 5 □ Resi 28d. Describe		Other (Spec	ify)
ion	Attending I death. ctor: After y the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	iy Year) Inj	ury M	Work? 1 □ Yes 2 [□No				
Division of Vital Records,	of or Attendate after death	ertification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At home, fam tc. (Specify)	n, street, factory	, office	1	28f. Location (City or To	Street and wn. State)	Number or Ru	ral Route Number,
	Hospitel or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	O		th E								
	To the Hospitel or vilthin 24 hours after within 24 hours after To the Funeral Direction plately filled in b	edicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best ner: On the basis o and manner st	of examination and/	death occurred or investigation	at the time, date a in my opinion, de	and place, a eath occurre	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	An V	111	290	License number	r _		29d. Date	signed (Month	, Day, Year)
			>	HARIN	4/120		DZS	933		4,	3.06	
			30. Name and address of person who co	empleted cause of	C10	ype, Print)	24/2 1	1.17	Fan.	1	Mr	31001
	Stat		31. Date filed (Month, Day, Year)	111)	rar's Signature	no I CHU	14NS h	HNL	L/19	ol (M)	1,117	21601
	Stat Registra		APR 0 6 2005	100	A	last .						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** CHARLES GORDON JONES, JR. MARCH 3:30 P^M 22 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNE ARUNDEL ANNAPOLIS 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F Director 213-38-7824 65 APR. 1, 1940 MD Usual Residence of Decedent or 28a-f show a notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 No MD QUEEN ANNE'S GRASONVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? treumatic event, the Medical Examiner must be Items 23a 205 JONES LANE 21638 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No 1958— 1 Yes, Give Year or Dates: 1964 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: WHITE 3 ☐ Widowed 4 N Divorced 1964 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) 10 POLICE OFFICER LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES GORDON JONES, SR. ဂ္ဂ ANNETTA MAY HANDLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES GORDON JONES, 111/SON 820 DIXON DRIVE, STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If Ite
eny injury or of
once. 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 03/27/2006 STEVENSVILLE, MD 21. Signature of Funeral Service L 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Small cell **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Qid tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only only examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dirac 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 22, 2006 cenine Weing, MI D52830 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road #300 Annapolis, MD 21401

State

Registrar

31. Date filed (Month, Day, Year)

32. Registar's Signature

2006

	Please T	ype or Print in Black Indelible Ink. Ensure	All Copies A	re Legib	ıle.
	For	State of Maryland / Department of Health an	d Mental Hygi	ene 📗	
1-	For , State Registrar	Certificate of Death		g. No.	C)
1.	Decedent's Name (First, Middle, Last)		2. Date of Death		Voar

)	Physici /Medic Examir	cal
	Funeral Director	i i

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at aging.

Judge, Danna

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after deeth.

To the Funeral Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		-	artment of F rtificate of		Ind McIna			UD	1600
Registrar Decedent's Name (First, Middle, Last)				Doutil	2 Date	neg of Death	J. No.		3. Time of De
DONNA LYNN JUDGE					Mon	ith	Day	Poolo	0845
a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, o	r Location o	MQJ f Death	(I)		y of Death	0010
Venoria i Hos	Dital FOS	iton	East	D. A	10 TV10	nd	Ta	inot	_
. Social Security Number 6. Sex	7. Age (In)	rs. last birthday)		If Under 2		of Birth	, ,	9. Birthp	lace (State or F
213-54-9551	M 2 X 1F 56	Yrs.	Months Days	Hours	08/1	7/19	49	WASHI	NGTON,
Jsual Residence of Decedent	10-	01. T							
0a. State 10b. County		City, Town or Lo	ocation					1	Od. Inside City L
MD QUEEN ANN	NE'S C	CENTREVI							
0e. Street and Number			10f. Zip Code			100	j. Citizen of	What Cour	ntry?
300 TWIN PONDS LAN		-116 12	21617		-0.461.44		JSA		and the discount
Marital Status Never Married 2 Married	12. Was Decedent Ever in Armed Forces?		Was Decedent of I If Yes, specify Cub	an, Mexican	nn? (Specify Yes , Puerto Rican, e	tc.)		ce - Americ ick, White,	
3 ₩Widowed 4 □ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:			Speci	[∱] :WHIT	E
15. Decedent's Educ		16a, Dece	dent's Usual Occup	ation		16	b. Kind of E		
(Specify only highest grade		(Give	kind of work done DO NOT use retire	during most	of working				20011)
Elementary/Secondary (0-12)	College (1-4or 5+) 4	ENTR	EPRENEUR			M	IARKET	ING	
7. Father's Name (First, Middle, Last)				18. Mother	r's Name (First, A				
JAMES W. DAVENPORT				ALTC!	E DICKER	SON			
19a. Informant's Name/Relationship (Typ	ре, Print)	19b. Maili	ng Address (Street				City or Town	, State, Zip	Code)
ABE HOPPER/FIANCEE		300	TWIN PONI	S T.AN	E CENTRE	VII I	E. MD	2161	7
0a. Method of Disposition		b. Place of Dispo		1	Date		c. Location		
1 ☐ Burial 2 【A Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	HESABEAI	CE CREMAT	ĨON	3/19/20	ne ST	EVENS	VTIIF	MD
21. Signature of Funeral Service License	9 (-20	2. Name and Addre	ss of Facility	7.7.1.7.7.20	00 5 2		ATHILL	, 1117
Nomas K. Ll	Il landrice	10	ELLOWS, H O6 SHAMRO	ELFENI CK RD	SEIN & N CHESTE	EWNAM R. MD	FUNE 216	RAL H	OME, P.
Sequentially list conditions, fany, leading to immediate ause. Enter Underlying ause. (Disease or injury hat initiated events esulting in death) Last	Due to (or as a con-								
any, leading to immediate ause. Enter Underlying Lause (Disease or injury hat initiated events esulting in death) Last FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a constitution of present the constitution o	sequence of): Ignancy Tetal death 3 E of death 5 E	□Ectopic pregnanc; □ Other (specify)					ate of delive	iry Day Yea
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			1 - State Registrar				Cei	tificate	e of L	Death			Reg. No	UUO	12300	
	Physici	-	Decedent's Name (First, Midd	ile, Last)								2. Date of Dea	ath Day	/ Year	3. Time of Death	
	/Medi		Floss	ie A				Jenki	ins			April	13,	2006	8:53 _A M	
	Examir		4a. Facility Name (If not institution	on, give stree	t and numl	ber)		4b. City,	Town, or	Location o	f Death		4c.	County of De	ath	
			Bayside Care	Center	ſ			Lex	kingt	on Pa	ark		5	t. Mar	v's	
	Funeral		5. Social Security Number	6. Sex	7	. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under a		8. Date of Birt (Month, Da	h		inthplace (State or Foreign Country)	
b.	Director		251-36-4467	1 □ M	2 🔼 F	81	Yrs.	MOTHES	Days	Hours	MIII.	Dec 18,			th Carolina	
	P.		Usual Residence of Decedent													
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5	within 72 hours after death with the Maryland ane. than "natural", or items 23s or 28s-f show the Madical Examiter must be notified at	Completed by	15. Decede (Specify only highe	nt's Educationst grade con	n n <i>pleted)</i>		16a. Deced (Give	ient's Usua kind of wor	l Occupa k done d	ition <i>Juring</i> most)	of workii	ng	16b. Ki	nd of Busines	s/Industry	
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anc	be fi	Be	17. Father's Name (First, Middle									(First, Middle,	Maiden	Sumame)		
Σ	should nd Mer marke umatic	မ	Lovick J. Sto									Sally				
Maryland 21215-0036	2 sh and ls m		19a. Informant's Name/Relation David Russell Jen				1	_				l Route Numbe				
	of Health Item 27 other tr			KINS /		70h B						ovevill				
0	Pages I		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Remo	val from St	ate C	lace of Dispo emetery, cren ood Hope	na <i>tory or</i> of	ther place	9)	D	ate		cation - City o		
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Itis Marical Examiner must be notified at QDGs.		21. Signature of Funeral Service	Licensee	1		. () 22			s of Facility y-Gard		Funeral	Home,	P.A.		
	40200		Unichael T	PLKIK.	Has	diver		P.0.	Box	270, L	eonar	dtown, M	D 206	50		
н			23a. Part1. Enter the disease, shock, or heart failure. Lis	r complication to only one ca	ns that cau	ised the death th line.	Do not ente	er the mode	e of dying	, such as o	cardiac o	r respiratory ar	rest,		Approximate Interval Between	
	Physician		tmmediate Cause (Final disease or condition	2	P	a en	men	-							Onset and Death	
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Э.	dea he at	SIC	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		nt at time of de		Other (spe						Month	Day Year	
<u>о</u> .	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	9 □ Unknewn													
Ś	es tha igned be de	by	Part II. Other significant conditi	- /	11/1 //	- Contraction of the Contraction	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did to	bacco u		to the cause of death?	
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œ	sician: The law certificate has b irector, page 2 s	Completed										autop. perfor	med?	death?	completion of cause of	
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Division of	g Phys er this eral di	L i	27. Manner of Death		Ba. Date of	Injury Day Year)	28b. Time of	28	Bc. Injury	at		8d. Describe h			Joney	
<u>ō</u>	Attending I r death. ector: After by the funer	ate	1 Netural 5 Pendi 2 Accident invest	ng igation	(MOHH),	Day (Gai)	Injury	м	Work 1 □ Y	? ′es 2 □ N	lo					
<u>Vis</u>	or Attendation of the death Director:	ifici	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		Be. Place of	Injury - At ho	me, farm, stre	et, factory,	office		2	8f. Location (S	treet and	Number or F	lural Route Number,	
Ö	al or s afte	Certification:	4 Homicide		building	, etc. (Specify	<i>(</i>)					City or Tow	n, State,			
5	Hospital 24 hours a Funeral tely filled		29a. Certifier 1 Certifyi	ng Physicia	n: To the b	est of my kno	wledge, death	occurred a	at the time	e, date and	place, a	nd due to the c	ause(s)	and manner a	s stated.	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examiner	On the bas	is of examinat	tion and/or inv	estigation,	in my op	inion, death	h occurre	d at the time, o	late and	place, and du	e to the cause(s)	
	To the Hospital within 24 hours a To the Funeral to completely filled	Ž	29b. Signature and title of certific	ST /					License		_	2	9d. Date	signed (Men	th, Day, Year)	
			1	X					DI	991	7		4/	13/0	6	
			30. Name and address of person	who comple	ted cause	of death (Item	23a) (Type, I		• /				/	/	/	
045			Dr. James C. 1	loyd, l	1.D.	2050 W:	ildewoo	od Cer	nter	Cali	forn	ia MD 2	0619)		
	Sta		31. Date filed (Month, Day, Year,		32. Reg	istrar's Signa										
5) 436	Registr	ar	APR 1 4 2	006	Nine.	, K	Beech	0								

Description Proposed Description Des			Por State Registrar	Please Type or Pri State of M	faryland / Dep		Health and M	ental Hyg	_	12367
## first Privacy Control Contr			1. Decedent's Name (First, A					2. Date of Deat	h Day Year	3. Time of Death 2005A M
100 Sizes 100 County 100	Examir Funeral	- 6	Doctors Comm 5. Social Security Number 220-40-3208	Munity Hospita 6. Sex 7. A	l ge (In yrs. last birthday)	Lan	ham If Under 24 Hrs.	(Month, Day,	Prince G	eorge's thplace (State or Foreign
Elementary/Secondary (0-12) College (1-40 Fa) Teacher	e Maryland	ctor	10a. State 10b. Co	ounty						10d. Inside City Limits XXYes 2 ☐ No
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Physician (Medical Examiner) Physic	ITIN it. Pa rtmen rtant: nlury		1 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth	ner (Specify)	Harmony	matory or other pla Mem. Par	k 4/1/	06	Landover,	Md.
OD STATE THAT IMPLIED TO THE PROPERTY OF THE P	Physician /Medical		23a. Part 1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	se, or complications that causes. List only one cause on sech	ed the death. Do not en					
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1 Yes 2 No 3 Probably 4 University 4	the death certification in the attending ached for use as	nysician/Me	23b. Was decedent pregnam in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth	2 Fetal death 3		у			
25. Was case referred to medical examiner? Second Se	equires that	ed by PI	Part II. Other significant cor	anditions contributing to death	but not resulting in the u	nderlying cause gr	ven in Part I.			
16 30. Narry and address of person who compreted cause of death (Item 23a) Type, Print) T313 Steep of Philoly of Huton 10 3. Vecel in MD Freen Bell My, 207	ral Reco		25. Was ease referred to me	adicat				autopsy perform	ned? death? PNo 1 ☐ Yes	
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Hutonio B. Valentin MD Breen belt Ny. 207	5 1 5 p	-	1 sh	most L	entar	Do	91425	3	3/27/	OG
State 31. Date filled (Month, Day, Year) 22. Hegistrar's Signature	Sta	te [®]	30. Name and address of pe	Year)	death (Item 23a) Type, Political Vision (Item 23a) Type, Iran's Signature	WD.	7313 Dre	Sub	ES FEX	1. 20770

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	Physici	an	Decedent's Name (First, Middle, Last Connie D. Jen	•				2. Date of Death Month	Day Year	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give			4b. City, Town	, or Location of Death	January	31, 2006 4c. County of Dea	9:35 A M
			Prince George's H			Cheve			Prince C	
	Funeral Director		5. Social Security Number 6. Social Security Number 79-42-4464 Usuel Residence of Decedent	9X 7. Age (□ M 2 🖾 F 4 2	(In yrs. last birtho	Months Day	s Hours Min.	8. Date of Birth (Month, Day, June 04	9. Bir Co 1,1963 DC	thplace (State or Foreign ountry)
	yland		10a. State 10b. County	1	10c. City, Town o	or Location				10d. Inside City Limits
	Be-fet	Director	Md PG]	Bowie					1X Yes 2 No
	eth with the 123s or 2	rai Dire	10e. Street and Number 1500 Pernell Co	ourt		10f. Zip Code 20716			og. Citizen of What Co	ountry?
36	be filed within 72 hours after deeth with the Maryland nial Hygiene. Be other than "naturel", or Iteme 23a or 28e-1 show event, the Medical Exercities must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates;	er in U.S.	 Was Decedent of If Yes, specify CL Yes 2 N 	f Hispanic Origin? (Spe ban, Mexican, Puerto o <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: B1	e, etc.
2-00	72 hounature		15. Decedent's Ed (Specify only highest gra	ucation	16a. D	ecedent's Usual Occ	upation	1	6b. Kind of Business	/Industry
21215-0036	ed within igneral	Completed	Elementary/Secondary (0-12) 11th	College (1-4or 5+)		fe. DO NOT use retile	e during most of worki red)	ng	None	
Maryland	2 should be file and Mental Hy Is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last) Wiley Stokes				18. Mother's Name			
	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (7 Lucinda Kenney()	• • • • • • • • • • • • • • • • • • • •			et and Number or Rura 1 Ct. Box			Zip Code)
Baltimore,	S		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of D cemeters Riverda	isposition (Name of crematory or other p ale Park	Crem 4/7/0	D	Oc. Location - City or iverdale	
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licen	61.8		22. Name and Add			Wash, nedy St.	DC NW 20011
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the cause on each line. a	Use	with (ying, such as cardiac of			Approximate Interval Between Onset and Death
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Вох	Attending Physicien: The law requires that the death certificate be exer death. r death. ector: After this certificete has been signed by the ettending physicien a by the funeral director, page 2 should be detached for use as the burial-	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1. □ Yes 2 □ No 9. □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tin 9 □ Unknown	Fetal death	3 ☐Ectopic pregnan 5 ☐ Other (specify)	псу		23d. Date of de Month	liv <i>e</i> ry Day Year
rds, P.O.	quires that n signed b	d by Ph	Part II. Other significant conditions co Chronic Alcoholism	ontributing to death but r	not resulting in th	ne underlying cause g	given in Part I.		acco use contribute to	1
Division of Vital Records,	The law requir sete has been si page 2 should	complete						24a. Was an autopsy perform 1X Yes 2	ed? prior to death?	utopsy findings available completion of cause of
Vita	Icien: Th certificete ector, pag	Be	25. Was case referred to medical examiner?	Hospital: 📆			26. Place of Death			
on of	ing Phys After this o	lon: To	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	2 ER/Outpa 28b. Tim (ear) Inju	e of 28c. Injury	ury at 2	ne 5 Residen 28d. Describe hov	nce 6 □Other (Spe v injury occurred	cify)
Divisio	l or Attendi after death. Director: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (r - At home, farm (Specify)	M 1 [yes 2□No	28f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
П	Hospita 4 hours Funeral ely filled	Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of r	kamination and/o	eath occurred at the or investigation, in my	time, date and place, a	and due to the cau	use(s) and manner as	s stated. It to the cause(s)
_	To the within 2. To the complet	Mec	29b. Signature and title of certifier	and manner stated	u.		nse number		d. Date signed (Mont	
			The I.	Kird m	w	0	.C.M.E.	Fe	ebruary 04	, 2006
CA	(2)		30. Name and address of person who of	completed we of deat			reet, Balti			
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 3 2006		Signatura	ale				

DHMH 17 Rev 1/2001

ORIGINAL

				State of M	arylan		artment of I <i>tificate of</i>		Mental Hyg	jiene leg. No.	5	12369
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea	th		3. Time of Death
	Physici /Medi		Seymour Mark Ker	yon					March 2	29 pay200	6 Year	12:15 PM
	Examir		4a. Facility Name (If not institution, gr	ve street and number)				•	Location of Death	4c. County	of Death	
			Montgomery Villa					Gaithers		Montg		
	Funeral		·	4 TO 14 OFF		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day 08-24-1	Year)	9. Birthp	lace (State or Foreign to) York
	Director.	6 8	050-20-0674 Usual Residence of Decedent	143 M 2UF 7	9	115.			08-24-1	926	New	York
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation	- Anna de cha			1	0d. Inside City Limits
	Mary Firsh	ģ	MD Montgom	ery	Germ	antowr	1					12⊠Yes 2 □ No
	r 28c	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Coun	try?
	23a c		34 Neerwinder Ct				20874	, +	U	.S.A.		
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,	S. 13. V	_		Specify Yes or No- to Rican, etc.)	14. Rac	e - Americ	
0	d within 72 hours after death with the Maryland liene. Then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at the Medical Examiner.		1 ☐ Never Married 2 ☑ Married	1 ⊠ Yes 2 □	No		☐ Yes 2 No	Specify:	to micari, etc.)		ck, White,	
8	ural',	Completed by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII					Specify	Whit	9
15	"nat	iete	15. Decedent's E (Specify only highest gr	ducation ade co <i>mpleted)</i>		16a. Deced	ent's Usual Occup kind of work done	ation during most of wo d)	rking	16b. Kind of B	usiness/Inc	ustry
12	withii ane.	Ĕ	Elementary/Secondary (0-12)	College (1-4or !	5+)	_		u)		Microb	1	
9	iled Hygi nt,		17. Father's Name (First, Middle, Las	5+	{	Docto	r	18. Mother's Na	me (First, Middle, I	Microb: Maiden Surnan		у
a	D O O	To Be	Carl Kenyon	,				Betty l			,	
Maryland 21215-0020	d 2 should be f th and Mental I 7 is marked of traumatic ave	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street		ural Route Number	; City or Town,	State, Zip	Code)
Ξ	alth a 27 is		Susan Kenyon-Wife	!		34 Ne	erwinder	Ct. Ger	mantown,	MD 208	74	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once.		20a. Method of Disposition	W	20b. Pl	ace of Dispos	sition (Name of atory or other pla	ce)	Date	20c. Location -	City or To	wn, State
<u><u>E</u></u>	Pag Try T		1 ☑ Burial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Speci				Cemeter		4-2-06	Farming	dale,	NY
alt	mit. spartr sports y inj		21. Signature of Funeral Service Lice	nsee		22.	Name and Addre	ss of FacilityEdv	ard Sage	1 Funer	al D	Lrection
ш	9 9 E 2 9		Donald (Ltott	Zemy	es-	.091 Rock	cville Pi	lke Rockv	ille, M	$^{\circ}$ 208	352
			23a. Part1. Enter the disease, or con shock, or heart tailure. List only	plications that caused	the death.	. Do not ente	r the mode of dyir	ng, such as cardia	c or respiratory arre	est,	1	Approximate Interval Between
	Physician	2 9									ŀ	Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	. AS	3180	27 75	15 GC	N 3000 50 C	212			
		Due to (or as a consequence of):										
	nsit	Ë	_	b. 5				-				
Ć,	v requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or	as a cullsaqu	ience of).				i	
68760,	ysicia e bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of).										
89	ng ph es th	_	resulting in death) Last		_ 10 ,0 (0.	40 4 00.10044					1	
Вох	th ce tendii or use	Physician/N	•	d							1	
E	e dea he at hed fo	Sici	Part II. Other significant conditions	contributing to death be	ut not resul	lting in the un	derlying cause giv	en in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
<u>о</u> .	The law requires that the death centere has been signed by the attendingage 2 should be deteched for use								1 □ Y	es 2 KNo	3 ☐ Prob	ably 4 ☐ Unknown
ds,	ires ti signe d be d	þ							ara.			
Š	requ	Completed							24a. Was a	n autopsy ned?	ava	re autopsy findings ilable prior to npletion of cause
9	* 00 CI	ם									of d	eath?
<u></u>	icete								1 □ Ye	s 2/ELNo	1 🗆	Yes 2⊠No
5	sicial certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 K No	Hospital:	0Ur	:D/O-11	a□ DOA Oth	or.	ath (Check only on			
ō	Phys or this eral d	2	27. Manner of Death	28a. Date of Injui (Month, Day		R/Outpatient 28b. Time of	28c. Injur	4Z_ITNUISING F	lome 5 ☐ Reside			,
<u></u>	ath.	at o	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio		Year)	Injury		k? Yes 2 □ No				
Division of Vital Records,	Attei er der by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At hon	ne, farm, stre	et, factory, office		28f. Location (St. City or Town		er or Rural	Route Number,
<u> </u>	tal or s afte al Dir	Se		bullaling, etc	. (Specify)				City of Town	, State)		
	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	edicai	29a. Certifier 12 Certifying Pt (Check only one)	nysician: To the best on niner: On the basis of and manner sta	examination	ledge, death on and/or inve	occurred at the tinestigation, in my of	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and ma ate and place, a	nner as sta and due to	ited. the cause(s)
	To the	Me	29b. Signature and little of certifier	1			29c. License	e number	29	d. Date signed	d (Month, E	ay, Year)
	3		▶	NA			HOE	51280		3-28	-4 c	262
7		-	30. Name and address of person who				rint)					- P
			Anushiravan Dadga					rrace Ge	rmantown,	MD 208	874	
	Star Registra		31. Date filed (Month, Day, Year) APR 0.5 20	32 Registra	ar's Signatu	ire Anas	Care D					
	negisti		71. 11 09 70	CO REAL SASTE	1 50	The same of	non-A-					

		For State Registrar 1. Decedent's Name (First, Middle, Last,							2. Date of D	eath	3 0	3. Time	of Death
Physici /Medi	_	Patr	icia	Dia	ne	L	ease		April	Da 9	y Yea 2006		3 A'
Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of Dea	ath	4c	. County of De		
	3.	Frederick Memoria					eder:				Freder		
uneral irector		5. Social Security Number 6. Sec. 2 2 0 - 5 4 - 9 7 9 4	K]M 2⊠F	. Age (In yrs. Ia	ist birthday) Yrs.	Months	1 Year Days	If Under 24 Hr Hours Mir	n. (Month, E	ay, Year)	(irthplace (State Country)	or Fore
ii cotoi		Usual Residence of Decedent		56					6/20/	1949		MD	
tal	_	10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside (
item 27 is marked other then "natural", or items 23s or 28s-f show other traumstic event, I'm Medical Exercit at must be notified at	Funeral Director	MD Frederi	ck	Fre	ederi							1 € Ye	5 2 🛄
a or	2	10e. Street and Number				10f. Zip				_	izen of What (Country?	
ns 23	era	700 Toll House	12. Was Deced	ent Ever in U.S	i. 13. V		701 dent of Hi	spanic Origin? ((Specify Yes or Narto Rican, etc.)		USA 14. Race - An	nerican Indian,	
and and and and and and and and and and	Fun	1 Never Married 2 XMarried	Armed Ford	No No					erto Rican, etc.)		Black, Wh	nite, etc.	
in in	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dat	es:		1 🗌 Yeş	ZILI No	Specify:			Specify:	Nhite	
"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of wo	rk done d	uring most of w	orking	16b. K	ind of Busines	ss/Industry	
E 2	шb	Elementary/Secondary (0-12) 1 2	College (1-4	tor 5+)		mema					Own Ho	. m.o	
other.	Be Co	17. Father's Name (First, Middle, Last)		1	110	шеша	KEI	18. Mother's Na	ame (First, Middl) III C	
rked Icev	ToB	Unknown						Unkno	w n				
e me		19a. Informant's Name/Relationship (Ty				-			Rural Route Num				
m 27		William R Lease	Sr Hu					Place		,			
or of	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emoval from SI	l co	ace of Dispo metery, cren	sition (Nai natory or c	ne of other place	1	Date			or Town, State	
rtant	١,	4 Donation 5 Other (Specify)	,	Smi	thsb				/14/06				
important: if Item 27 is eny injury or other trai once.		21. Signature of Euneral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A.											
		23a. Part1. Enter the disease, or complished, or heart failure. List only or	cations that car	used the death.			East Church Street Frederick MD 21 a mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between						
hysicien and the burial-transit	Il Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	r as a consequer as a consequer	ence of):								
by the attending phy ached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 □ Fetal nt at time of de	death 3	Ectopic p					23d. Date of d Month	lelivery Day	Year
90	l by F	Part II. Other significant conditions con	tributing to dea	th but not resul				n in Part I.	-			to the cause of Probably 4	
peen	etec	Coronary	() =	7 01	21.24	ase							
SC	Completed	Trecen 1	+13100	9 05	SEPS	>1.2			24a. Wa auto per 1 🗆 Yes	opsy ormed? 2 X No	prior to death?	autopsy findings o completion of ? es 2□ No	cause
certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			14	Othe		eath (Check only				
ir this aral di	. To	1 Yes 2 No	1 🗆 Inp		R/Outpatien 28b. Time of)M	4 Nursing	Home 5 ☐ Res 28d. Describe			ecify)	
: After s funer	tior	1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,	Day Year)	Injury	М	28c. Injury Work 1 🔲 Y	? ′es 2 □ No		, ,	,		
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place o building	f Injury - At hor g, etc. (Specify)	ne, farm, str	eet, factor	y, office		28f. Location City or To	(Street and	nd Number or I	Rural Route Nui	mber,
Funera letely fille	edical (29a. Certifier 1 Certifying Physical Condition (Check only one) 2 Medical Exami	sician: To the b ner: On the bas and manne	is of examinati	rledge, death on and/or in:	occurred vestigation	at the tim , in my op	e, date and plac inion, death occ	ce, and due to the curred at the time	cause(s) , date and	and manner a place, and di	as stated. ue to the cause	(s)
To th	Me	29b. Signature and title of certifier				290	c. License	number		29d. Da	te signed (Moi	nth, Day, Year)	
		1/hune				ì	200	6041	7	4.	9.20	006	
	1 1	30. Name and address of person who co	mpleted cause	of death (Item	23a) (Type,						KM		
7	Ī	Hemen shah				Tohr			1-				

			1 - For State Registrar	State of Maryla		artment of I			ene 0 0 6	12371
	Physic /Medi		Decedent's Name (First, Middle, Last,	Ty Lam				2. Date of Death Month	Day Year	3. Time of Death 10: 15 A M
	Examir Funeral Director		4a. Facility Name (If not institution, give BAUTIMORE WAShin 5. Social Security Number 6. Security Number 224-83-9745	gton Medical	s. last birthday)	4b. City, Town, of the Under 1 Year Months Days		S. 8. Date of Birth	0.00	ath Cundel thplace (State or Foreign ountry) Vietnam
	Aaryland Febow	or	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Aru		City, Town or Lo			7 42.0 237	2337	10d. Inside City Limits 12 Yes 2 \(\text{No} \)
	ath with the Marylan 23a or 28a-f ehow	al Director	10e. Street and Number 1833 Montreal Ro			Sev 10f. Zip Code 211		10g	. Citizen of What C	
980	within 72 hours atter death with the Maryland ene. than "nature!", or iteme 23a or 28e-f ehow he Madicel Exeminer must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of h f Yes, specify Cub	an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	7 E - F	Completed	15. Decedent's Edu (Specify only highest grad		(Give life. L	dent's Usual Occup kind of work done DO NOT use retire L'eacher	during most of w	orking 16	b. Kind of Business Privat	•
ryland ;	be file Ital Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Lam Dich					ame (First, Middle, Ma Nguyen Thi	iden Sumame) Thau	
	s 1 and of Health item 27		19a. Informant's Name/Relationship (Ty Dat Lam (Son) 20a. Method of Disposition	20b.	1833	Montrea	l Road,	Severn, MD Date 20		
Baltimore,	permit. Pag Department o Important: If any injury or on		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensy	C	hesapea 22	ke Crema . Name and Addre	tory 4/7	//2006 B dendon/Hale ad, Lanham		Home
	Physician physician and physic	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the dealer cause on each line. Uncol to or as a consecutive to for a consecutive to for a consecuti	ath. Do not enter dernia quence of): Hhro quence of):		ng, such as cardi	ac or respiratory arrest		Approximate Interval Between Opset and Death HINWES
Box 6	that the death certifica led by the attending ph detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗌	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	ivery Day Year
Ω.	8 5 6	Þ.	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause giv	en in Part I.		co use contribute to	o the cause of death?
tal Reco	n: The law r ficate hes be or, page 2 sh	e Completed	25. Was case referred to medical					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospitel or Attending Physician: The within 24 Hours after death. To the Funerel Director: After this certificate he pompletely filled in by the funeral director, page	TO B	examiner?	ospital: 1 npatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing	Home 5 Residence 28d. Describe how		cify)
Divis	itel or Atte	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At t building, etc. (Speci	(fy)	,		28f. Location (Stree City or Town, S	itate)	
	To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in by	Medical	29a. Certifier (Chack only one) 1 ✓ Certifying Physical Examinates (Chack only one) 2 → Medical Examinates (Chack only one) 29b. Signature and title of certifier	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	estigation, in my o	pinion, death occ	urred at the time, date	and place, and due	to the cause(s)
)	F 3 F 8		· Haira Cau	vo	m gant or	29c. Licens		14 Ap	CIT 3 2	006 006
	Sta	10	30. Name and address of perion who con MARIA GAVIRIA 31. Date filed (Month, Day, Year)	301 Hoo,	of Dri	ve Gler	Brnic	2 MD 211	101	
100	Sta Registr		APR 0 5 2006	en # A	and s					

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F		and Me		jiene	5	12372
			1. Decedent's Name (First, Middle,	Last)				2	. Date of Dea	th		3. Time of Death
	Physic /Medi		JUNG IM	LEE] ;	Month MARCH	29, 20	0 6	6.40AM
	Exami	ner	4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of	f Death		4c. County of	Death	
			RANDOLPH HILL			WHEAT				MONTO	OME	RY
	Funeral Director		5. Social Security Number 6 220 19 5176 Usual Residence of Decedent	. Sex 7. Ag 1 ☐ M 2 ☑ F	9 0 Yrs.	Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day) AY 03	, 1915	Birthpl Count S •	
	72 hours after death with the Maryland neture!', or items 23e or 28a-1 show dicul Evanings must be notified at		10a. State 10b. County		10c. City, Town or Le	ocation					10	Od. Inside City Limits
	ours after death with the Marylan ret', or Items 23e or 28a-f show Everimer must be notified at	tor	MD MONTG	OMERY	WHEATO	N						1 ∑ Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			1	0g. Citizen of Wh	at Coun	try?
	ath w		4011 RANDOLPH	RD		20902	2			S. KOF	REA	
	ter dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	jin? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Race -	America White, e	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Z	No	1 ☐ Yes 25 No	Specify:			Specify:		
Ş	72 hours neturel',	edb	15. Decedent's	Year or Dates:		dent's Usual Occup	ation					
21215-0036	S	Completed	(Specify only highest	rade completed)	(Give	kind of work done of DO NOT use retired	durina most	of working		16b. Kind of Busin	ness/ina	ustry
212		mo	Elementary/Secondary (0-12)	College (1-4or 5		SEWIFE	•			PRIVA	ጥፑ	
	be filed ttal Hygi d other event, I	Be C	17. Father's Name (First, Middle, La	st)			18. Mother	r's Name (F	First, Middle, I	Maiden Sumame)	السلاسلين	
/lai		To	JUNG SOOK L	EE			S	0	Al	HN		
Maryland	and and arm		19a. Informant's Name/Relationship			ng Address (Street a			loute Number			
	f Health item 27 other tr		YOUNG OH	/ SON	the state of the s	30 VIERS	MIL:			610 ROC	KVI	LLE MD
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plac	e)	Date	9 2	20c. Location - Ci	ty or Tov	wn, State
ŧΞ	t. Pa rtmen rtant: njury		`4 Donation o Other (Spe		NORBECK		L į	3/31,	/06 (OLNEY	MD	
Bal	permit. Page Department of Important: If any injury or		21. Signature o Funeral S y cell	ensee S		2. Name and Address 2303 KAY				INDS FU MARLBOR		
	/Medical Examiner bubysician and street braining street st	Examiner	23a. Part1. Enbetha disease, of co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nipuy that initiated events resulting in death) Last	a. Branch Due to (or as b. Due to (or as c.	a consequence of): a consequence of):	em s	1	Ke				Interval Between Onset and Death 3 UPCAYS
P.O. Box 68760,	death certi e attending od for use a	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	d	2 Fetal death 3	Ectopic pregnancy Other (specify)				23d. Date o Month		y Day Year
ŝ	w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use contribu s 2.XNo 3[cause of death?
	The law ate has b page 2 sl	Completed						_	24a. Was an autopsy perform	prio dea	r to com: th?	sy findings available pletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Otho	215		heck only one			
	Phyer this ral dii	- To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie		-	4 A Nurs			nce 6 Other (Specify)	
0	ding Ph th. After th funeral	tlon	1 Natural 5 Pending	(Month, Day	Year) Injury	Work	? ′es 2.⊟No	1	. Describe no	w injury occurred		
Division of	Il or Attending after death. Director: After I in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not determine	be 200 Bloom of their	rry - At home, farm, stre :. (Specify)			-	Location (Str. City or Town,	eet and Number of State)	or Rural i	Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	thysician: To the best of the miner: On the basis of and manner sta	examination and/or inv	occurred at the tim restigation, in my op	e, date and i	place, and occurred a	due to the car at the time, da	use(s) and manne te and place, and	or as stat	ted. he cause(s)
	To th To th somp	Me	29b. Signature and title of certifier			29c. License	number		29	d. Date signed (N	fonth, Da	ay, Year)
)	7		20 Name and	a completed as	7 		210	33	17.	narchi	3/,	2006
			30. Name and address of person who DR BYOUNG LE	E 13000 G	A. AVE. S	Print) SILVER S	PRINC	G MD	2090)6		
	Sta Registra		31. Date filed (Month, Day, Year) APR 0 5 2006	32. Registra	r's Signature	*)						

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State of Maryland / Department of Health and Mental Hygien	е
Certificate of Death	

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Reg. No.	Law		U	-	-	U	- #	۷.,

Mariey Ayeli Lega	all
	1- For State Registrar
Physicia Medical Examir	
	4a Facility I
Funeral	5. Social Se

Director

permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other tranmatic event, the Medical Examiner must be notified at once,

Baltimore, MD 21215-0036 Physician /Medical -xaminer

To the Hospital or Attending Physician: The law requires that the death certificate he executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transit Division of Vital Records, P.O. Box 68760,

ian/ iner	Decedent's Nam			0011)ay	Year		ne of Death '06 hrs
III ICI	4- Facility Name /	Marley		gall	41	b. City, Town, a	r Location of I		April 10, 20		ounty of Dea		
	4a Facility Name (Washington	n Adventist		umber)	-	Takoma P	ark			Mo	ntgomery		
\neg	5. Social Security I	Number 6	Sex	7. Age (In yrs. la	ast birthday)		-		. Date of Birth	(MM/DI		irthplace ountry)	(State or Forei
	215-75-30		1 M 2 F		Yrs.	Months Da	,	Min.	March 2	6,		• /	and
	Usual Residence of 10a. State	10b. County		10c. City,	Town or Location	on							nside City Limit
<u>_</u>]	Maryland	Montgo	mery	Tal	koma Par	k						1 XX	Yes 2 N
양	10e. Street and Nu		-			10f. Zip Code			10g	. Citizei	n of What Co	untry?	
Director	8313 R	loanoke	Avenue #	2		20	912		1	Unit	ed St	tates	S
Funeral	11. Marital Status 1 X Never Marr	ried 2 Ma	12. Was De rried Armed F 1 Yes	cedent Ever in U. forces? 2 X No		Decedent of Hes, specify Cuba				14	Race - Ame White, etc.	erican Ind	dian, Black,
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Completed by	15. Decedent's E	Education (Spec	fy only highest gra	ade completed)	16a. Decedent' during	s Usual Occupa	ation (Give kir	nd of work	done 1	6b. Kin	d of Business	s/Industry	/
ete	Elementary/Sec	condary (0-12)	College ((1-4 or 5+)		orking life. DO	NOT use retir	red)					
ш	0				Non A	pplicat	1e			N	Von App	plica	able
	17. Father's Name	e (First, Middle, I	_ast)				18 Mother's	Name (Fi	rst, Middle, Ma	iden Su	ırname)		
Be	Mark L							n Tay					
0	19a. Informant's N	lame/Relationsh	ip (Type, Print)			Address (Stre							ode)
	Mark and 20a. Method of Dis	sposition		20b. l	8313 Place of Disposit crematory or other						cation - City o		0912 State
	4 Donation 5 21. Signature of Fi	5 Other Spe	ecify.	Ga	te of He	eaven C		04/1 Pope 5538	5/2006 Fune Marlb	S: ral oro	Homes Pike		ng,Md.
	23a. Part I. Enter the failure List of	the disease, or only one cause of	complications that on each line.	caused the death	. Do not enter th	e mode of dying	j, such as car	Fore	stvill.	e. M	id. 20		roximate Interv ween Onset an
	Immediate Cause or condition result	(Final disease	a. Anoma.	lous coron		ies							Death
al Examiner	Sequentially list c if any, leading to i cause. Enter Und (Disease or injury events resulting in	immediate derlying Cause that initiated in death) Last	c. Due to (or as	a consequence of	of):	-OE/ 1/r							
dic	XUNPENDE	D	AMENDED	item#23a	,2/,penul	,g8504,4/∠	10/06 11						
sician/Medical	IF FEMALE: 23b. Was deceden past 12 month	ns?	1 Live	nant at time of de	2 Fet	al death 3 ner (Specify)	Ectopic	pregnancy	/		Date of delive lonth	ery Day	Year
۲۶	Part II. Other sign				resulting in the u	nderlying cause	given in Part	r I	23e Did tob	acco us	e contribute t	n the cau	ise of death?
by	Part II. Other sign	micant conditi	Mis continuating	to death but not i	esciting in the di	nderrying eduse	giveiriiri dit		1 Yes				4 V Unknown
Completed by Phy									24a. Was an autopsy	,		complet	indings availab ion of cause of
ő									1 Y Yes 2		1 🗸	Yes	2 No
Be	25. Was case refe	erred to medical				26.Pla	ce of Death (C	Check only	y one)				
0	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing H	lome 5 R	esidend	ce 6 Oth	ner:	
tion: T	27. Manner of Dea 1 X Natural 2 Accident	5 Pend	(Mon	e of Injury th, Day,Year)	28b. Time of Ir	njury 28c In	ury at Work? Yes 2 1		d Describe ho	w injury	occurred		
Medical Certification:	2 Accident 3 Suicide 4 Homicide	6 Could		ice of Injury - At h	iome, farm, stree	t, factory, office	building, etc.	28	f. Location (Str or Town, Sta		Number or F	Rural Rou	ute Number, Cit
dical (29a. Certifier 1 (Check only one) 2	= <u>.</u>	ysician: To the be niner:On the basis and manner	s of examination a									e(s)
ž	29b. Signature an	d title of certifier				29c Licer	ise number			29d Da	ite signed (N	fonth, Da	y, Year)
	30. Name and add	dress of person	Haul	ELU — use of death (Iten	n 23a)	0.0	c.M.E.			April	12, 2006		
	Carol Allar	n, MD Ass	sistant Medica	I Examiner	111 Penn S	Street, Baltir	nore, MD	21201					
ate tra r	תת ז	nth, Day, Year) 1 3 200	- 7	Registrar's Signat	ure	r							
001					ORIGINAL	L							

DHMH 17 Rev 1/2001 OCME 10/2003

Registrar

1 - For State Registrar		Maryland / Depa	artment of Health and tificate of Death	Mental Hygi	-	12374
Discontainer	me (First, Middle, Last) Atwood Marine			2. Date of Death Month	Day Year	3. Time of Death
/iviedical	(If not institution, give street and numb		4h Chu Tanana and and and		31 2006	/707 M
	, Course Made	1 Parket	4b. City, Town, or Location of De	ath	4c. County of Death	20
Funeral 5. Social Security		Age (In yrs. last birthday)	If Under 1 Year If Under 24 H	rs. 8. Date of Birth		
Director 219-14-3	3715 ¹™ 2□F	81 Yrs.	Months Days Hours Mi	n. 8. Date of Birth (Month, Day, Feb. 8,1	925 Penn	ace (State or Foreign try) SV1vania
Usual Residence	of Decedent 10b. County	10c. City, Town or Lo				
Jack of Parties			Cation		10	od. Inside City Limits 1 X Yes 2 No
Maryland 10e. Street and N	Wicomico	Sharptown	10f. Zip Code	10	- 63	
Maryland 10e. Street and N 711 Stat 11. Marital Status 11 Never Ma 11 Never Ma 3 □ Widowed	e Street		21861	10	g. Citizen of What Coun	try ?
11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Vas Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	USA 14. Race - America	an Indian.
O affe of the local state of th	Armed Force rried 2 🕅 Marned 1 🕅 Yes 2 If Yes, Give	□Nº 1747-		erto Rican, etc.)	Black, White, e	
12-0036 Maryland 10e. Street and N 711 Stat 711 Stat 711 Stat 711 Stat 711 Stat 711 Stat 711 Marital Status 711 Stat 711 Stat 712 Weden with the Maryland 713 State 714 State 715 Weden with the Maryland 715 State 716 State 717 Weden with the Maryland 718 State	4 Divorced Year or Date	is: 1743	I ☐ Yes 2 💢 No Specify:		Specify: Whit	e
21215-0 de de within 72 hou your than "natura Compiered	15. Decedent's Education acify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 16	6b. Kind of Business/Ind	ustry
Elementary/Sec	condary (0-12) College (1-4)	or 5+)	nery Assembler		anufacturin	ı G
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ed bluone of the man o	Atwood Marine		Edna G	race Beave	r	
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Number or I	Rural Route Number, (City or Town, State, Zip	Code)
Betty J. 20a. Method of Di	Marine/Wife	P. 1	O. Box 374, Shar			
O O O The A TO Descript of	2 ☐ Cremation 3 ☐ Removal from Sta	III	natory or other place)	Date 20	oc. Location - City or Tov	vn, State
Battimore Important: ## 1500 To a control of the control of th	5 Other (Specify)			/2006 S1	har town, M	aryland
Baffi Depending Construction of State o	rull D. Sl	Ver Z	Name and Address of Facility Lier Funeral Ho	me, P. O.	Box 3171	
234. Part. Enter	the disease, ir complications that caus	sed the death. Do not ente	212 Old Ocean Ci	TY KOAD, S	alisbury, M	ID 21802 Approximate
Physician Immediate Cause disease or conditi	(Final	of Ine.	VOT 1	1. 1	1 0	Interval Between Onset and Death
/Medical resulting in death	a	as a consequence of):	J. Marcon 18	- Liza	3/ ham 6	
Examiner Sequentially list c	onditions. b.	7 zocare	har sch	emia		daz
Sequentially list of if any, leading to it cause. Inter Und Cause (Disease o that initiated event	mmediate Due to (or erlying	consequence of):	09 7) •		0
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w require the should sh						*
al Record The law requir The law requir Page 2 should Completed				24a. Was an autopsy performe	✓ prior to com	sy findings available pletion of cause of
Confice de confice de	rred to medical		26 Place of De	1 Yes 2	No 1 ☐ Yes 2	□ No
The control of the co	Hospital: 1 ☐ Inpa	itient 2 D-ER/Outpatient	Other		e 6 □Other (Specify)	
27. Manner of ea	th 28a. Date of In 5 Pending (Month, D		28c. Injury at Work?	28d. Describe how		
Vision Attending Attending Attending Attending Attending Attending Attending Attending Attending Attending Attending Attending Attending	investigation		M 1 ☐ Yes 2 ☐ No			
Division of Vital Records, s after death. el Director: After this certificate has been signe ed in by the funeral director, page 2 should be considered by the funeral director, page 2 should be considered by the funeral director, page 2 should be considered by the funeral director, page 2 should be considered by the funeral director, page 2 should be considered by the funeral director, page 2 should be considered by the funeral director of the considered by the funeral director of the function of the funeral director of the funeral director of the function of the function of the funeral director of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the funeral director of the funeral director of	determined 289. Place of t	Injury - At home, farm, stre etc. (Specify)	et, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural i State)	Rou <i>te Numb</i> er,
strong 29a. Certifier	Certifying Physician: To the best	st of my knowledge, death	occurred at the time, date and place	e and due to the caus	ea(s) and manner as state	od
Division of Vita To the Hospital or Attending Physicien: Within 24 hours after death. To the Funerei Director: After this centific completely filled in by the funeral director. To the Honoride after death. To the	2 Medical Examiner: On the basis	of examination and/or investated.	estigation, in my opinion, death occ	urred at the time, date	and place, and due to the	he cause(s)
29b. Signature and	Hithe of certifier		29c. License number		Date signed (Month, Da	ay, Year)
7 9	1700		D20441		4-2-06	
	ress of person who completed cause of	death (Item 23a) (Type, P	D2044/ t. Salisbury			
State 31. Date filed (Mor	APR 9 5 2006 ^{22. Regis}	ar's Signature	. Salisbury	MD 2	180/	
Registrar	WALK & D TORP	Var's Signature	porte			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend items 6,10d,11-14 per fh 9854 4-19-06 vt

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Geraldine Myers April 11 2006 1:00 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Avalon Manor Health Care Center Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 200 F 189-18-6895 86 Yrs. Sept. 10 1919 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Washington Hagerstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 14014 Marsh Pike 21740 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Specify: 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Garment Mfg. Co. Laborer 8 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Mummart Bessie French 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor Myers/Daughter-In-Law 15075 Mercersburg Rd. Greencastle, Pa. 17225 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition complete, crematory of other place)
Macedonia United
Brethren Church Cemetery 1XBurial 2 ☐ Cremation 3 ☐ Removal from State 4/14/06 Greencastle, Pa. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. On. Unnew 45 S. Carlisle St. Greencastle Pa. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chronic Renal railure disease or condition resulting in death) Due to (or as a consequence of) cnsion Hyper Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown men 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1126

0060396

29d. Date signed (Month, Day, Year)

11740

04/11/06

Box 68760. P.O. Division of Vital Records.

Hospital or Attending Physicien: The law requires that the death certificate be executed

use as the burial-transit attending for use as ed by the a ate has been signed I page 2 should be det certificate director this After thi death. the within 24 hours after deat To the Funeral Director: filled in by completely

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Physician

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Funeral

Director

28e-f show

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al Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any finity or other traumatic event 2008.

Physician

/Medical

Examiner

the Medical Examiner must be notified at

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Completed

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Examiner

Physician/Medical

Be Completed by

Medical Certification: To

the Maryland

death

filed withIn 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) 9 2006

ARID

29b. Signature and title of certifier

M

newhood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

(Check only one)

29a. Certifier



and manner stated.

1

		1	For State Registrar	State of Ma	aryland.		artment <i>tificate</i>			and M		iene.	6	12377
	Physicia		Decedent's Name (First, Middle, Last		36		_	-			2. Date of Deal Month April		00gr	3. Time of Death
Н	/Medic	al -		Warren	Marti	Ln	0.02.3			4.0	April	1Z Z		2:35 P. M
	Examin	er	4a. Facility Name (If not institution, give 19226 Woodhaven					own.or erst	Location o	of Death			hing	
			5. Social Security Number 6. Se		e (In yrs. last	birthday)	If Under	1 Year	If Under		8. Date of Birth			
	Funeral Director			MM 2□F	73	Yrs.	Months	Days	Hours	Min.	Feb 19	1933	Man	hplace (State or Foreign unity) Cyland
	D s		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	Aaryla f sho	5	MD. Washing	ton		agers								1 ☐ Yes 2 X No
	the N	rect	10e. Street and Number		L		10f. Zip	Code			1	0g. Citizen of	What Co	ountry?
	h with	ai D	19226 Woodhaven I	r.			2	1742				U.S.	Α.	
336	be filad within 72 hours attar death with the Maryland that Hyglena. ad other than "netural", or flems 23a or 28a-f show event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	1		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe 1, Puerto	ecity Yes or No- Rican, etc.)	Bla	ice - Ame ack, Whit ify: Wh	
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Maryland 21215-0036	d 2 shi th and th sm 17 is m traum		19a Informant's Name/Relationship (7 Naomi R. Martin/Wi			19b. Mailii 1922	ng Address 6 Woo	(Street a dhav	en Di	er or Rura	d Route Number agerstow	n, City or Town	217	Zip Code) 42
ore,	es 1 an of Haal fitam 2 r other		20a. Method of Disposition 19≅ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	e of Dispo	sition (Name matory or of ennon	ne of ther place	9)		1	20c. Location	-	
ij	hait. Page pertment cortant: fr injury o		`4 □ Donation 5 □ Other (Specify)		ch Ce	meter	У		4/19	9/06	Leite	rsbu	rg, Md.
Baltimore,	permit. Pages 'Department of H Important: if its any injury or of		21. Signature of Funeral Service Licen H. Martin Zu	meim	·~	4	5 S.	man Carl	And S isle	Son I	Tuneral Greenca	stle,	nc. Pa.	17225
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	Examiner		Sequentially list conditions	b										months
. /	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):								
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8760,	ate ba hysicla tha bur	ical		d			_	-						
O. Box 6	daath certif s attanding d for usa a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal de	eath 3	⊒Ectopic pr ⊒ Other (sp						ate of de	ivery Day Year
ds, P.	g og ⊒	þ	Part II. Other significant conditions of	ontributing to death I	out not resulti	ng in the u	inderlying c	ause give	en in Part I		23e. Did to	_/		o the cause of death?
of Vital Records,	e la has	Completed									24a. Was a autop: perfor	sv	prior to death?	utopsy findings available completion of cause of
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× ×	Physician: r this cartific ral diractor,	10	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		VOutpatie	-				me 5 Resid			cify)
		on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inj (Month, Da	ay Year)	8b. Time o Injury	of 2 M	8c. Injury Work	/at <br Yes 2.∐	1	28d. Describe h	ow injury occi	urrea	
Division	be of	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	jury - At hom tc. (Specify)	e, farm, st				-	28f. Location (S City or Tow		nber or R	ural Route Number,
	Hospital 4 hours Funaral aly filled	edical Co	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the besi niner: On the basis of and manner s	of examinatio	edge, dear n and/or ir	th occurred ivestigation	at the tim	ne, date ar pinion, dea	nd place, ath occuri	and due to the cred at the time, c	ause(s) and n date and place	nanner as a, and due	s stated. e to the cause(s)
	To tha within 2 To tha complat	Me	29b. Signature and title of certifier		A	^			number		3	29d. Date sign		
			Guelerie	Live	1	mij	1	52	363	-3	1	trul	15	Zuro 6
	20		30. Name and address of person who Frederick H. Ka					nie I	Rd h	ager	stown N	۸d .		
	Sta	ate.	31. Date filed (Month, Day, Year)		rar's Signatu		· oami	m Cuo	···· II	ager	Scowii, I	14.		
	Regist		APR 1 9 2	2006	we l	1	make	,						

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	oartment o ertificate		nd Mental	Hygiene Rag. No.	06	2378
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date Mon	of Death th Day	Year	3. Time of Death
	/Medi	cal	Georgia Ann M			4. 6. 7	77	Apr		2006	7:30 A M
	Examir	ner	4a. Facility Name (If not institution, give				vn, or Location of			County of Death	_
	Funeral		La Casa LLC As 5. Social Security Number 6. Se	sisted I	iving e (In yrs. last birthde	y) If Under 1 Y	polis	4 Hrs. 8. Date	of Birth	ne Aru	place (State or Foreign
	Director		577-36-8287	_ м жок ғ	75 Yrs.	Months D	ays Hours	Min. Jun	of Birth th, Day, Year) e 2,19	30 Vir	ginia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	f sho	ō	Maryland Anne An	mel	Annapol						1 ☐ Yes 2 X No
	1 the 1 28e	Director	10e. Street and Number			10f. Zip Co	de		10g. Citiz	en of What Cou	ntry?
	th with	ai D	2574 South Haven	Road		214	01		U	SA	
	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show adjoal Examprise must be muilised at	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ♣ N	Ever in U.S. 1	3. Was Decedent If Yes, specify	of Hispanic Orig Cuban, Mexican,	in? (Specify Yes Puerto Rican, et	or No-	4. Race - Ameri Black, White,	
21215-0036	urs aff	þ	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 €	No Specify:			Specify: Whi	te
2-0	72 hor	Completed	15. Decedent's Edu (Specify only highest grad		16a. De	cedent's Usual O	ccupation	of working	16b. Kir	d of Business/In	ndustry
21	ithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5		omemake	one during most etired)	or working	Δ:	Home	
2,	filed within Hygiene. Ither than "		12 17. Father's Name (First, Middle, Last)			On Charte.		's Name (First, A			
Maryland	d la b	To Be	William		Crouch		Lilli		nodie, walden	Swarz	mann
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (T)	ype, Print)	19b. Ma	iling Address (St	reet and Number	or Rural Route	Number, City or	Town, State, Zip	o Code)
	of Health Item 27		Michael J. Maggio	- Son			way Dr.,				
ore	000=====		20a. Method of Disposition **Data Burial 2 Cremation 3	Removal from State		rematory or other	r place)	Date		cation - City or To	
Baltimore,	+ E # -	1	*4 □ Donation 5 □ Other (Specify, 21. Signatur 2 Juneral Service Licens		•		1	-			ville, MD
Ba	Depar Impo		· Gege 1?	Cols		2973_Sol	ddress of Facility . Kalas omons	Island Ro	i., Ed	, P.A.	r, MD 2103
			23a. Parti Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each lin	the death. Do not e	nter the mode of	dying, such as c	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical	1	Immediate Cause (Final disease or condition resulting in death)	. Liast	untest	rhal	In	pectro	2		Orisot and Doam
	Examiner			Due to (or as a	a consequence, of):	Ces	PSO				
		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	a consequence of):	, , , ,					
	cuted nd ransit	Examiner	triat initiated events	. Can	cer,	ung					
90,	sate be executed obysician and the burial-transit	EX	resulting in death) Last	Due to (or as a	a consequence of):	•					
8760,	physic physic s the b	dicai		d							
9 x	i h certific tending p or use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				2	3d. Date of deliv	en/
Box.	dea h e atler d for u	Physician/Med	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal death	☐Ectopic pregn☐ Other (specif				Month	Day Year
P.0.	t the de by the tached	hys	9 Unknown	9□ Unknown							
ds, F	as the gned be de	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the	underlying caus	e given in Part I.	23e.		^	he cause of death?
Sor	w require been si should I	letec						242			
Records,	The lav ate has page 2	Completed						1	Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
Vital	iclan: Th certiticate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check			5.5.04 T. 5.4T 7.4
of V	Physiclan: this certitic ral director,	2	1 ☐ Yes 2 🔀 No		nt 2 ER/Outpat			sing Home 5		Other (S	sisted Ving
	ling Atter	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day			Injury at Work? 1 ☐ Yes 2 ☐ N		cribe how injury	occurred	
Division	deatl deatl ctor: / the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At home, farm,				tion (Street and	Number or Rura	al Route Number.
Οİ	in Dirt	Certification:	4 Homicide	building, etc	(Specity)	,,,		City	or Town, State)		
	e Hospitel or 24 hours atte e Funeral Dir. letely tilled in l	edical (29a. Certifier 1⊠ Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of ner: On the basis of	examination and/or	ath occurred at thinvestigation, in a	ne time, date and my opinion, death	place, and due to occurred at the	o the cause(s) time, date and	and manner as solace, and due to	tated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner sta	ted.	29c. Ļi	cense number		29d. Date	signed (Month,	Day, Year)
)	- s - ŏ		Mariarl	onces	Mig	Δ	05202	3	Apr	111,	2006
	10		30. Name and address of person who co	ompleted cause of de	eath (Item 23a) (Typ	200	Annapoli	s MD 2	1401		
	Sta	te	Maria Romero, 31. Date filed (Month, Day, Year)	32 Registra	2 Defense or's Signature	I I W Y	mapon	ک تاہا ہی			
	Registr	1	APR 1 8 20	06 Maria	J. J. A	aske!					

				artment of Health and Me	ental Hygier	0000 10075
			Decedent's Name (First, Middle, Last)	2	Date of Death	3. Time of Death
	Physicia /Medic		Curtis McBride Mast	A		2006 Year 7:18 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Holy Cross Hospital	Silver Spring		Montgomery
Н	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 213-24-3547 76 Yrs.	Months Days Hours Min.	Date of Birth (Month, Day, Yea OC. 9, 1	9. Birthplace (State or Foreign Country) 929 Boone, NC
	p		Usual Residence of Decedent			
	ahov	ž	Maryland Calvert 10c. City, Town or L			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28e-f	Director	Maryland Calvert Owin	IGS 10f. Zip Code	100	Citizen of What Country?
	3a or		9120 Southern Maryland Blvd.	20736	109.	USA
	deeth	Funerai	11. Maritaf Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No-	14. Race - American Indian,
စ္က	within 72 hours after deeth with the Maryland ene. than "natural", or itema 23a or 28e-f ahow ha Madical Examiner must be notified at	y Fu	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 No Specify:	can, etc.)	Black, White, etc. Specify: White
Š	hours tural',	ed by	3 Wildowed 4 Divorced Year or Dates:			MILEC
21215-0036	n na	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	166.	Kind of Business/Industry
212	d with	mo:	Elementary/Secondary (0-12)	ctronic Technician		Private
9	al Hy d other	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
yla	Ment Ment Barked	2	Joseph Wheeler Mast		McBride	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic avant, the Madical Examiner must be notified at once.			ing Address (Street and Number or Rural F 3 Ark Ct. Bowie, MD		y or Town, State, Zip Code)
	Heall Heall tam 2 other		20a. Method of Disposition 20b. Place of Disp	osition (Name of Date		Location - City or Town, State
Ē	Pages ent of nt: If i			itan Crematory 4-5-0		exandria, VA
altimore,	Depertm Depertm Importa any inju	- 1	* * * * * * * * * * * * * * * * * * * *	0. 11	LL Funera	
<u> </u>	89 E 8 8			512 NW Crain Hwy. I	Bowie, MI	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such 😸 cardiac or r	s iratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	cual (Illy)	umic	Onset and Death
	/Medical Examiner		Due to (or as a consequency of):	many Dula	2/1	04.04.04
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	onary and	y al	XUV
	outed id ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		1	
Ö,	e exection ar		resulting in death) Last Due to (or as a consequence of):			
8760	cate be executed physicien and the burial-transit	dicai	d			
9	attending p	യം⊩	IF FEMALE: 23c. If yes, outcome of pregnancy			
Вох	atten d for u	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	t the c by the	hysi	9 Unknown			
S, P	angue o	by P	Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ord	w require been si should t	ted	- masay unu au	gast '	1 ☐ Yes	2 No 3 Probably 4 Dunknown
Records,	law r	Completed	Pelepheral Vasulli a	MUN	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
					performed?	death?
Vita	ysician: This certificate	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (C		
ō	두 두 등	2	27. Manner of Death 28a. Date of Injury 28b. Time of	1 3 COA 4 Industrig nome	5 Residence d. Describe how in	6 ☐Other (Specify) jury occurred
<u></u>	Ntending I death. ctor: After y the funer	ation	1 ☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		. ,
Division		Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f	Location (Street City or Town, Sta	and Number or Rural Route Number,
	Hospitat or A 24 hours after Funeral Dira tely filled in by					
	L 4 II 0	edicai	29a. Certifier (Creach only one) 1. Certifying Physicien: To the best of my knowledge, deat control one of the control one of	n occurred at the time, date and place, and vestigation, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
	To the Vithin 2. To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d. D	Pate, signed (Month, Day, Year)
				56147	4	14/06
0	((0)	1	30. Name and address of person who completed cause of death (ftem 23a) (Type,	Print)	7	100
	<u> </u>		NASREEN KANGO 7610 CAR	ROLL AVE 205, 1	AKOMA	PARK, MD 20878
2	Sta Registra		31. Date filed (Month, Day, Year) APR 0 5 2006	the p		
			MER U D LUNU AND AND AND AND AND AND AND AND AND AND			

	Í	1 - For State Registrar	State of Maryland		tificate of		-	Reg. No.	06	12380
Physicia /Medica		1. Decedent's Name (First, Middle, Last, John W. McCoy S	Sr.	· · · · · · · · · · · · · · · · · · ·			2. Date of Dea Month March	30 ^{Day}	2006	3. Time of Death 16:48
Examine	er	4a. Facility Name (If not institution, give Holy Cross Hospit	al		4b. City, Town, o	Spring			nty of Death	ry
Funeral Director		5. Social Security Number 577-40-2232 Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		1925	9. Birth Cou	place (State or Forei intry) Marylan
-f show fied at	tor	10a. State 10b. County DC		Town or Lo						10d. Inside City Lim
A or 288	Director	10e. Street and Number		\	10f. Zip Code			10g. Citizen		intry?
	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1	81	20012 Vas Decedent of H Yes, specify Cuba ☐ Yes 25 No	ispanic Origin? (n, Mexican, Pue Specity:	Specify Yes or No- irto Rican, etc.)		Race - Ameri Black, White,	etc.
iene. r then "nathen he	Completed	15. Decedent's Edu (Specify only highest grade	cation completed) College (1-4or 5+) 2yrs	(Give I	ent's Usual Occup kind of work done of OO NOT use retired	during most of w		Priva		ndustry
Mental H arked oth	To Be	17. Father's Name (First, Middle, Last) John W. McCoy				Etta Co				
penint. Tagges I and 25 should be lied Department of Health and Mental Hyg Importent: If Item 27 Is marked other any Injury or other traumatic event, angle.		19a. Informant's Name/Relationship (Ty, Peggy McCoy / Wife 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State Quar	608 T ce of Dispos metery, crem ntico	ewkesbury ition (Name of atory or other place National	P1. NW Ce.Apr.		ton, D 20c. Locatio Triang	C 2001 on - City or To (1e, V	L2 own, State
hysician /Medical xaminer xaminer-transit	edical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque CHRONIC OBSTR Due to (or as a conseque Due to (or as a conseque	CUCTIV	E LUNG DI	ISEASE				
been signed by the attending p should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 □Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 □I	Ectopic pregnancy Other (specify)			1	Date of delive	ery Day Year
en signed buld be del	2	Part II. Other significant conditions con CARCINOMA OF THE		ing in the un	derlying cause give	n in Part I.		bacco use co es 2 □ No		ne cause of death? pably 4 □Unknow
page 2 sh	Completed						24a. Was a autops perform	med?	D. Were auto prior to co death? 1 \(\text{Yes}	psy findings availat mpletion of cause o
tor: After this c	0	25. Was case referred to medical examiner? 1 Yes 2 No		NOutpatient Bb. Time of Injury e, farm, street	28c. Injury Work M 1 \(\)	4 🗆 Nursing	eath Check only on Home 5 Reside 28d. Describe ho 28f. Location (SI City or Town	ence 6 Co	urred	
within 24 hours after o	edical	29a. Certifier 1 M Certifying Phys (Check only one) 2 Medical Exemin	ician: To the best of my knowledge: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the timestigation, in my op	e, date and plac inion, death occ	e, and due to the curred at the time, d	ause(s) and r ate and place	manner as si	tated. o the cause(s)
Tot	2	29b. Signature and title of certifier	Harth	i M	29c. License			^{9d. Date sigr}		
State		30. Name and address of person who a Mark K. Li, MD 1 31. Date filed (Month, Day, Year)	npleted cause of death (Item 2 721 University 2. Registrar's Signatur	Blvd.		eaton,	MD 20902			

e S .90		Mwa	akasaka Please Type or State of		d / Depa	rtment of H	leaith and Me	ental Hyg	iene	. 12381
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Alice Samuel Mwakasaka		Cer	tificate of		2. Date of Deat Month March	n Day 200	3. Time of Death 2:13 A ^M
	Examir		4a. Facility Name (If not institution, give street and no 3147 Queen's Chapel Roa			Mt. R	r Location of Death		1	George's
ı	Funeral Director		5. Social Security Number 218-73-6550 6. Sex 1 ☐ M 2	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, .2-31-19	9. 1 950 Te	Birthplace (State or Foreign Country) Anzania
	a-f ahow	ctor	10a. State 10b. County Maryland P.G.	10c. City	Mount	cation Rainier				10d. Inside City Limits 1 1 Yes 2 □ No
	ath with the	ral Director	10e. Street and Number 3147 Queens Chapel Road			10f. Zip Code 207			Og. Citizen of What	ia
036	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ahow any Injury or other treumatic avent, the Medical Entitliar minal to collined at once.	by Funeral	Armed F	2 K] No live	i	Vas Decedent of H f Yes, specify Cubi I ☐ Yes 2 2 No	lispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- lican, etc.)	14. Race - A Black, W Specify:	
Maryland 21215-0036	vithin 72 horne. ne. han "naturi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	(1-4or 5+)	(Give life. L		during most of working d)	g	16b. Kind of Busine Health Se	•
and 2	id be filed w ental Hygiei ked other ti ic avent, ti	To Be Co	17. Father's Name (First, Middle, Last) Samuel Mwakasaka		Kegis	tered Nu	rse 18. Mother's Name Tupilik	(First, Middle, M	Maiden Sumame)	
	end 2 should ealth and Men n 27 is marke ier treumatic	-	19a. Informant's Name/Relationship (Type, Print) William Ngeze / Son		Dares	ssalaam,	and Number or Rural 0 Tanzania		, City or Town, State	a, Zip Code)
Baltimore,	Peges 1 (ment of He tant: If Iten		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)		nily Ce	sition (Name of natory or other place emetery	04-18-	-2006		anzania
Bai	permit. Depertricularity Imports any Inju		21. Signature of Funeral Service Licensee **Danca C. Bacs 23a. Part 1. Enter the disease, or complications that	on cc	36/ 3	447 14th		.W. Was	hington,	D.C. 20010
	Physician /Medical Examiner		shock, or heert failure. List only one cause on immediate Cause (Finaf disease or condition resulting in death)	each line. MOSU o (or as a consequence)	mote	1	diovasc		/ \	Interval Between Onset and Death
3/60,	ate be executed hysicien end ihe burial-transit	Ilcal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	o (or as a consequ						
O. Box 6	The law requires that the death certificate be the best been signed by the ettending physicion aggle 2 should be deteched for use as the but	Physician/Medical	230. Was decedent pregnant	utcome of pregna birth 2 Fetel gnant at time of de nown	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
rds, P.	quires that I in signed by uld be dete	Ď	Part II. Other significant conditions contributing to	death but not resu	ulting in the ur	nderlying cause gn	ven in Part I.	23e. Did tot	A	e to the cause of death? Probably 4 Unknown
al Reco	i: The law re- icate hes bee r, page 2 sho	Completed						24a. Was a autops perform	y prior ned? dea	autopsy findings available to completion of cause of 1? es 2 No
Division of Vital Records, P.O. Box 68/6	To the Hospital or Attending Physician: The laventhin 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2	atlon: To Be	27. Manner of Death 28a. Date	Inpatient 2 De of Injury	ER/Outpatien 28b. Time of Injury	28c. Inju	4 Nursing Hom	ne 5 ☐ Reside	e) ence 6X1Other (S ow injury occurred	Specify) SCENE
Divis	tal or Atters after dei Diracto	Certification:		ce of Injury - At ho ding, etc. (Specify		eet, factory, office	2	8f. Location (St City or Town		Rural Route Number.
	the Hospital or in 24 hours afte the Funerel Dir pletely filled in	edical	// \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			vestigation, in my	opinion, death occurre	d at the time, d	ate and place, and	due to the cause(s)
	To the complete complete	Σ	29b. Signature and rittle of certifier	M			O.C.M.E.		9d. Date signed (M March 18,	
	de		30. Name and address of person who in lot car		111	Print) . Penn St	reet, Balt	imore,	Maryland	21201
	Sta Reg ist	ate rar	APR 0 4 2006	Registrar's Signa	lure					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 28, Mar. 2006 Dorothy Henrietta Monaco 5:30a /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel Under 24 Hrs Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 TXTF 88 Director Mar. 6, 1918 Washington, DC 579-16-7827 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Itema 23a or 28a-f ahow tre Madical Examiner must be notified at MD Anne Arundel Annapolis 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 933 Edgewood Road, Apr. 215 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 11 of Health and Mental Hygie f Itam 27 is marked other t r other traumatic event, IL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorenzo Corcoran Bessie Ecton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darlene Monaco/Daughter 125 Longfellow Drive, Millersville, MD 21108 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or o Apr. 8, 1 XBurial 2 Cremation 3 Removal from State Trinity Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD 2006 21. Signature of Funeral Service Licensei Barranco & Sons, P.A. Severna Park Funeral Home AMES 495 Gov. Ritchie Hwy, Severna Park, MD 6 ant. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate C luse (Final Vere Physician disease or condition resulting in heath) /Medical Due to (or as a consequence of): Examiner equentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ metastal1c ovarian Curcer 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed clementin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop sy perform certificete 20 No 26 No 1 Yes 1 Tyes Division of Vital the Hospital or Attending Physician: Be 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) € Inpatient 2 EN/Outpatient 3 DOA 1 Yes 25 No 2 After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 \ Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TU Motames 006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ned arkway 00 1 Con de 31. Date filed (Month, Day, Year) . Registrar's Signature State APR 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sonth Curch **Physician** 2006 Concetta Venera North /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore-Washington Med. Ctr. Glen Burnie Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Apr. 2, 1920 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 85 MD Director 216-20-3482 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28e-f show treumatic event, the Medical Examination must be notified at MD 1 ☐ Yes 2 No Anne Arundel Arnold Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Howard Avenue 21012 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 Yes 2X No Specify: Specify. Completed by 3 X Widowed 4 □ Divorced 2 should be filed within 72 hours and Mental Hygiene. Is marked other than "natural", Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Salvatore Maranto Sarah Citrano ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 Is r 406 Howard Avenue, Arnold, MD Joyce R. North/Daughter Date 4, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr. 2006 1 Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Lakeview Memorial Baltimore, MD `4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, 21. Signature of Funeral Service Licenses Severna Park Funeral Home Severna Park, MD 21146 nomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dolymo ni /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and hed tor use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached tor in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) _ 9 Unknown 9 🗍 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ed bluods 2 XNo 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 ☐ Yes 2 ☐ No or Attending Physician: tilled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on 2 No Hospital: Other: 2 hpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 1 Yes 5 Residence 6 Other (Specify) Manner of Death

Natural

Call Accident Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after death. Certification: 5 Pending investigation 1 TYes 2 No М 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel 5 To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number manh 3/ 2006 Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Cherma 31. Date filed (Month, Day, Year) State Registrar

0ZKUL

Yrs.

10c. City, Town or Location

7. Age (In yrs. last birthday)

Certificate of Death

4b. City, Town, or Location of Death

SILVER SPRING

If Under 1 Year If Under 24 Hrs.

Hours

Min

Days

with the Maryland Show or 28a-f show a notified at MD. MONTGOMERY BROOKEVILLE Direct 10e. Street and Number 10f. Zip Code r than "natural", or iteme 23a or the Medical Examiner must be 20833 20624 NEW HAMPSHIRE AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ρ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) il Hygiane. other than HOMEMAKER permit. Pages 1 and 2 should be filed w Department of Health and Mentai Hygiar important: if item 27 is marked other then you injury or other traumatic event. Its ADGS. 17. Father's Name (First, Middle, Last) HOPKINS SAMUEL CATHERINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) AHMET OZKUL, HUSBAND AHMET, HUSBAND -AHMET 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State SALEM CEMETERY 4/07/06 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MURIEL H. BARBER FUNERAL HOME Barker moriel W. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COLORECTAL CANCER **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ng physicien and es tha buriai-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ page 2 should Completed 24a. Was an has certificete 1 ☐ Yes To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifice 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 1 ☐ Yes 2 🔀 No ٩ 2 ER/Outpatient 3□ DOA ŧ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: Injury 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) δ 4 🗌 Homicide

State
Registral VEND#19aperFH4/5/06, EMV, McCo

ELIZABETH

1 ☐ M 2 🛣 F

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

10b. County

1. Decedent's Name (First, Middle, Last)

MARY

5. Social Security Number

226 78 0889

10a, State

Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

3. Time of Death

3, 2006 Year Month April 1:30 A 4c. County of Death

Reg. No.

2. Date of Death

MONTGOMERY

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) VIRGINIA Jan.20,1952

10d. Inside City Limits 1 XYes 2 □ No

> 10g. Citizen of What Country? UNITED STATES

14. Race - American Indian, Black, White, etc.

Specify: WHITE

16b. Kind of Business/Industry

OWN HOME 18. Mother's Name (First, Middle, Maiden Surname)

WALKER

20624 NEW HAMPSHIRE, BROOKEVILLE, MD.

20c. Location - City or Town, State

BROOKEVILLE, MD.

P.O. BOX 5038, LAYTONSVILLE MD.

20882

Approximate Interval Between Onset and Death YEARS

23d. Date of delivery Month Day

Year

23e. Did tobacco use contribute to the cause of death?

2 **N**o 3 Probably 4 Unknown 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?
Yes 2 No 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 154378 Apr. 13 2000

30. Name and address of per on who compleyed cause of death (Item 23a) (Type, Print) M.D., 2730 UNIVERSITY BLVD. W., #400, WHEATON, MD. 20902 CHERYL AYLESWORTH,

31. Date filed (Month, Day, Year) State

29b. Signature and little of certifier

(Check only one)

2006 0.5

32 Registrar's Signature

CSWIN

Registrar

cal

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** March 31, Mark L. Pincus 2006 5:54P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F Yrs. 58 Director 220-48-8063 11-1-1947 Washington, DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20878 907 Main Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: if tem 27 is marked other than "natural", or its eny injury or other treumatic event, the Madical Examina page. 1 □ Yes 2 ♠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: β Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Management Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Saul Pincus Helen Solomon ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 907 Main Street Gaithersburg, MD 20878 Marsha Pincus/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Garden 4-2-06 Olney, MD 4 ☐ Donation \(\square \square \square \square \text{Other (Specify)} \) 22 Danzansky Goldberg Memorial Chapels, Inc. 21. Signature of Funeral Service Licensee 1170 Rockville Pike Rockville, MD 20852 1 1 pm Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardine **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icete hes been sig. 3 Probably 4 d Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy r this certificate h 1□ Yes 2.2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient ٩ 1 🗆 Inpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medicai Certification: Injury 1 Matural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu М 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) Do057155 200C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Saxena MD 9901 Medical Center Drive Rockville, MD 20850 32 Registrar's Signature State 05 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** ĂPRIL 7, 2006 9:30 P M HELEN PRINTZ /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner REEDERS MEMORIAL HOME BOONSBORO WASHINGTON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🔯 F Yrs. Director SEPT. 15, 1928 416-36-5004 ALABAMA Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d, Inside City Limits Mode I ral, or itema 23a or 28a-f ehor Examiner must be notified at 1 ☐ Yes 2 X No MARYLAND WASHINGTON BOONSBORO Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18233 LAPPANS ROAD 21713 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Maryland 21215-003(δ 3 ☐ Widowed 4 ☐ Divorced WHITE 'natural' Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 REGISTERED NURSE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental H PHENIE TAYLOR ZIBE BEARD 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Heelth at Important: If Item 27 Is any Injury or other trau MARVIN E. PRINTZ/SPOUSE 18233 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 04/12/2006 BOONSBORO, MARYLAND BOONSBORO CEMETERY 21. Signature of Pune/al Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Algherinen Diream Sauce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ Cardio Varale 1 Yes 2 No 3 Probably 4 Durknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cardionsopolh 24a, Was an autopsy performed? icete he Hypologicalin 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) certifi Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 မ After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending 1 Maturat М 1 ☐ Yes 2 ☐ No investigation s efter deeth 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eff
To the Funeral Di
completely filled in To the Hospital 🗲 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ARIL 8,2006 P1081 a COUTE MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-4 21740/301-739-7100 VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 1 (

MP

Box 68760,

ORIGINAL

parker

32. Registrar's Signature

			For State Registrar	State of	Marylar		artment of H rtificate of		ind M		jiene	6	12387
	Dhysiai		1. Decedent's Name (First, Middle	, Last)						2. Date of Deal		Year	3. Time of Death
	Physicia /Medic		Charles Alexa							March	<u> </u>	2006	2:04 A M
	Examin	er	4a. Facility Name (If not institution		ber)		4b. City, Town, o	or Location of polis	f Death		4c. County	of Death Arun	đel
(K)			600 Admiral Dri 5. Social Security Number		. Age (In vrs.	last birthday)	If Under 1 Year		24 Hrs.	8. Date of Birth			
4.	Funeral Director		577 52 4055	1 ⊠ M 2□F	90		Months Days	Hours	Min.	(Month, Day,	3,1915	<i>Cour</i> Fra	place (State or Foreign ntry) NCC
	ס		Usual Residence of Decedent										
	arylar show	_	10a. State 10b. County	Arundel	10c. Ci	ty, Town or Lo Annap						1	0d. Inside City Limits 1 ☐ Yes 3 No
	he M.	ecto	-	ALUIGEL		MILICIE					Og. Citizen of	A/h a h Causa	
	e or 2	Funeral Director	10e. Street and Number	4507			10f. Zip Code 214	01		'	Franc		uy?
	ns 23	eral	600 Admiral Dri	12. Was Deced	lent Ever in U	J.S. 13.			in? (Spe	cify Yes or No-		e - Americ	can Indian,
(0	ifter d ir Iten	Fun	1 Never Married 2 Marri	Armed Ford	2€ No	i	Was Decedent of I		, Puerto F	Rican, etc.)		ck, White,	
03	72 hours after death with the Maryland natural, or Items 23s or 28s-f show jiest Evantral be neillfied at	l by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	tes:		1 ☐ Yes 2 ☐ MANO	Specify:			Specif	w Whi	te
5-0	72 h "natu	ete	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of workir	ng	16b. Kind of B	usiness/In	dustry
21215-0036	within iene. t han "I	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		refighte.	-			Publ:	ic Sa	fety
d 2	filed Hygi other		17. Father's Name (First, Middle,	Last)				18. Mother		(First, Middle, I		ne)	
Maryland	ges 1 and 2 should be liled within 72 hours after death with the Marylan to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28a-f show or other treumetic event, Ira Marical Examiner mast tennillied at	To Be	Henri Pujol							Gireau			
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationsh				ng Address <i>(Street</i> West Fri						
	s 1 and 2 of Health item 27		Danielle Farri/ 20a. Method of Disposition	Daugnter	20b. F	Place of Dispo	sition (Name of	1			20c. Location		
nor	Pages nent of h ant: If its ary or o		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S)		tate i	_	matory or other pla cematory	-	4-1-	06 E	Edgewat	er, M	aryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Juneral Service		100		2. Name and Addre						
ä	permit. Departn Imports any inju		14'llul				73 Solom						
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	used the deat ch line.	th. Do not en	er the mode of dyi	ng, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a	Pr	estat	e Can	20					Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):							3
	a. 11	5	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consec	nuence of):						-	
	nted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	•		,							
Ć,	be executed sician and burial-transit	Еха	that initiated events resulting in death) Last	Due to (c	r as a consec	quence of):					-		
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	by Physician/Medical		d									
9	artifica ing ph e as th	Med	IF FEMALE:										
Box	ath ce	jan/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	al death 3	Ectopic pregnanc	у				te of delive onth	ery Day Year
0	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of o	Jean 5L	Other (specify) _						
9	ires that the death certific signed by the attending p d be detached for use as:	Ph.	Part II. Other significant condition	ns contributing to dea	ath but not res	sulting in the u	nderlying cause gr	ven in Part I.		23e. Did tol	bacco use con	tribute to t	ne cause of death?
ds	quires n sign ald be	q p								1 □ Y	es 2 🗆 No	3 🗌 Prob	pably 4 Dunknown
Records,	aw requir s been si 2 should	Completed								24a. Was a	ın 24b.	Were auto	psy findings available mpletion of cause of
R	The tay	mo								autops perform	med?	death? 1 🔲 Yes	2□ No
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	3						(Check only on	ne)		
of V	di S	P	1 ☐ Yes 2 ♠No			ER/Outpatie				ne 5X Reside			y)
n c	ling P	ion	27. Manner of Death 1 Natural 5 Pendin	9	Injury , Day Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 □ h		28d. Describe h	ow injury occur	red	
Division	or Attending latter death. Director: After in by the funer	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be 200 Place	of Injury - At h	ome farm st	reet, factory, office	1103 2	_	28f. Location (SI	treet and Numl	oer or Rura	al Route Number,
Div	after Direct	Certification:	4 Homicide determ	buildin	g, etc. (Speci	fy)				City or Town	n, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical	g Physicien: To the I Exeminer: On the ba	sis of examina	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and opinion, deat	d place, a	and due to the ca	ause(s) and make,	anner as s and due to	tated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and mann	er stated.		29c. Licens	se number		2	29d. Date signe	d (Month,	Day, Year)
	T.M. S		Madal	Nalt			0	5181	9		Merch	31	2006
				who completed cause	1			4. ~					<i>j</i>
	3.63		31. Date filed (Month, Day, Year)	32. PA	histrar's Sign	ature	المراسات	MO	,	2791			
	Sta Registi		APR 0		Second Second	N A	book						

		For State Registrar	State of Maryl		tificate of		Re	g. No.	12386
Physicia /Medica	in al	Decedent's Name (First, Middle, La CHARLES	FREDER	RICK	PEPP	IN r Location of Death	2. Date of Death Month	Day Year	2:15 A
Funeral Director		088-14-4808 Usual Residence of Decedent 10a. State 10b. County	pita1 Sex 7. Age (In 83	yrs. last birthday) Yrs. City, Town or Lo	Leonar If Under 1 Year Months Days	dtown		St. Mar	
th the Ma or 28a-t	Director	Maryland Charle 10e. Street and Number	S E	lughesvi]	10f. Zip Code		10	g. Citizen of What C	<u>-</u>
urs after death v it', or items 23s	by Funeral	15080 Cedar Broo	12. Was Decedent Ever Armed Forces? 1		2063 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:		USA 14. Race - Arr Black, Wh Specify: W	ite, etc. hite
filed within 72 I Hygiene. other then *net ent, Ire M. die	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Sollege (1-4or 5+)	16a. Deced (Give life. Nur	dent's Usual Occup kind of work done DO NOT use retired	during most of word)	king	U.S. Ai	
id be file ental Hy ked oth ic svent	To Be (17. Father's Name (First, Middle, Las Philip F.	Peppin			18. Mother's Nar	ne (First, Middle, N Fh	Skinner	
alth and M	-	19a. Informant's Name/Relationship Alicia P. Mrozow	(Type, Print)			and Number or Ru	ıral Route Number,		Zip Code) 20637 aryland
Pages 1 and of Heiston of Heiston of Heiston of Heiston or other ary or other		20a. Method of Disposition 1	_Hemoval from State		sition (Name of natory or other place Nationa	1		20c. Location - City o	
Physician /Medical Examiner,	edical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	0	death. Do not ent at the first of the first	.O. Box	128, Cha	rlotte Ha	Home, P.A 11, Maryl	Approximate Interval Between Onset and Death
the death certification of the attending posterior of the death of the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	olivery Day Year
w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions Demention Straice:	contributing to death but not	t resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob 1 ☐ Ye 24a. Was an	s 2 No 3 F	to the cause of death? Probably 4 Unknown
	Completed	25. Was case referred to medical					autopsy perform 1 Yes 2	prior to death? No 1 Ye	completion of cause of
ding Physician: h. After this certific funeral director,	To Be	examiner?		2 ER/Outpatien	t 3 DOA Cth		ith <i>(Check only one</i> lome 5 ☐ Reside	nce 6 Other (Sp	ecify)
ten feat for: the	Certification;	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not 1 determined	DB Diago of Injury	At home, farm, str		yat k? Yes 2 □ No	28d. Describe hore 28f. Location (Str. City or Town,	eet and Number or F	Rural Route Number,
To the Hospitel or At within 24 hours after of to the Funeret Direct completely filled in by	edical Cert	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exam	knowledge, death	n occurred at the tir	me, date and place	, and due to the ca	use(s) and manner a	is stated.
QC	Medi	29b. Signature and tille of certifier 30. Name and address of person who	and manner stated.		29c. Licens			D4/13	th, Day, Year)
Stat Registra	100	MEHIZOPO A 31. Date filed (Month, Day, Year) APR 1 4 2	32 egistrar's S		and)				

DHMH 17 Rev 1/2001

Charles reppin

			1 - Stata Amend Ite	State of Marylan Sm 23a, Pt Iper	d√Dep Dr.Ce	artment 3540 rtificate	49/20	alth a 706dh eath	nd Me	ental Hy	giene	006	123	889
1	Physici	an.	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day			of Death
	Physici /Medio			ABETH PAG	E					April	7, 2	2006	6:1	OA M
	Examir	er	4a. Facility Name (If not institution, give s Civista Medical					Location of	f Death			County of De		
			5. Social Security Number 6. Sex		last birthday		Plat	If Under 2	24 Hrs.	B. Date of Bir		Charles	rthplace (Star	e or Foreign
18	Funeral Director			м 2[ХТ 84	Yrs.	Months	Days	Hours		B. Date of Bir (Month, Da DEC • 20			RYLAN	_
	72 hours atter death with the Maryland natural', or items 23s or 28s-f show deal Exant at must be notified at		10a. State 10b. County	10c. Cit	y, Town or L	ocation								City Limits
	a-f sl	ctor	MARYLAND CHARLE	ES	WAL	DORF							1 🗆 Y	es 2⊠No
	or 28	Directo	10e. Street and Number			10f. Zip					10g. Citi	zen of What C	country?	
	s 23a	ra	1024 COPLEY AVE.		0 10		2060		:-0 (0	it. Van as Na		U.S.		
	er de	Funeral	T. Maria States	2. Was Decedent Ever in U. Armed Forces?	.S. 13.	If Yes, speci	ent of His ify Cuban	panic Orig i, Mexican,	, Puerto R	ify Yes or No ican, etc.))-	14. Race - Arr Black, Wh		•
36	irs att	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 22 No If Yes, Give Year or Dates:		1 ☐ Yes 2	XNo	Specify:				Specify: W	HITE	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23s or 28s-f show minortant: If Item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other traumatic event, its Medical Exaction of must be notified at DDGs.	ted	15. Decedent's Educ	cation	16a. Dece	edent's Usua e kind of won	l Occupa	tion	of workin	2	16b. Ki	nd of Busines	s/Industry	
215	within 7 iene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	mig most	OF WORKIN	9				
21	filed wi Hygien other th	Cou	6		DIS	ABLEI						I/A		
pur	be fill stal H d oth	Be	17. Father's Name (First, Middle, Last)	_						(First, Middle	, Maiden	Sumame)		
3	should be and Mental is marked o	ဥ	RUDOLPH B . PAG 19a. Informant's Name/Relationship (Type		10h Maili	ing Address	(Stroot as		G.		or City o	r Town, State,	Zin Codo)	
Maryland	d 2 sho th and t7 ie mu traum		SHIRLEY PAGE-SI			-						IARYLA		603
	Health tem 27 other tr		20a. Method of Disposition	20b. P	face of Disp	osition (Nam	e of	1	Da			cation - City of		
Baltimore,	Pages nent of I int; If Its iry or o		Burial 2 □ Cremation 3 □ Re Donation 5 □ Other (Specify)	emoval from State TRINITY	emetery, cre M F: M ∩	-			_12-	-06	TAT A T	DORF,	MADVI	AND
ij	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service License		The state of the s	2. Name and	Address	s of Facility	/					AND
m	Depar Impor any Ir		Muchael	0.5	4	RAYM	IOND	FUN	IERAI	SER	VICE	P.A	•	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications, or heart failure. List only on the state of the	Due to (or as a conseq	Pira Cla	a for	y or dying	Faller	lu	respiratory a	11651,		Approxin Interval I Onset ar	Between
	outed Id ansit	E	that initiated events C	1	nei	Imo	mi	a	0					
8760,	cate be executed physician and s the burial-transit	The search of the state of the												
.O. Box 6	Physician of the law requires that the death centricate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	□Ectopic pre					-	23d. Date of d Month	elivery Day	Year		
Ω.	res that igned b	by Pi	Part tt. Other significant conditions con	tributing to death but not res	ulting in the u	underlying ca	ause givei	n in Part I.		23e. Did t	obacco u	se contribute	to the cause of	of death?
Records,	w require been sig should b	ed	Severe	Obstix	atio	n				10	Yes 2	™No 3 □ F	robably 4	□Unknown
000	law requase been 2 should	Completed	montal	Returda	hon					24a. Was		24b. Were a	utopsy findin	gs available
R	The ate his page	ĕ	Dohid	mahan	, ,					perfo	rmed?	death? 1 ☐ Ye		, 04430 01
Vital	ding Physician. The law n. After ans certiticate has E funeral director, page 2 s	Be	25. Was case referred to medical examiner?	100101				26. Place	of Death	(Check only	one)			
of \	hysic this co	၉	1 ☐ Yes 2 2 No H		ER/Outpatie			4 LI NUI				6 □Other (Sp	ecify)	
n O	ding P. After tunera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28	Bc. Injury Work	at ? ′es 2 □ N		3d. Describe	how injur	y occurred		
Division	if or Attending after death. I Director: After d in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural City or Town, State)								Rural Route N	umber,		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of my knower: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred a nvestigation,	at the time in my op	e, date and inion, deat	d place, and the occurre	nd due to the d at the time,	cause(s) date and	and manner a I place, and du	as stated. le to the caus	e(s)
	To t To t	Σ	29b. Signature and title of certifier	()		29c.	License				29d. Dat	e signed (Mor	/	")
)			Mus	Ina	8		D-57	7708				1-7-	080	
	١		30. Name and address of person who co											
	1		Abbas A. Omais,	MD Cenna Med:		enter	7 C	Post	Offi	ce Roa	ad Wa	ldorf,	MD 206	02
4	Sta Regist		APR 2 0 2006	32. Aegistrar s Signa	Road	20								

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PAGE

VIRGINIA

		State of Maryland / Department of Health and M	ental Hyg	jiene _{eg. No.}	006	12390	
		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	th Day	Year	3. Time of Death	
Physicia /Medic		Donald E. Punt	Apr	7	2006	11:32P	
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. Co	ounty of Death		
		115 Jonathan St. Apt. 407 Hagerstown		<u>V</u>	<i>lashing</i>	ton	
Funeral		5. Social Security Number 6. Sex $1 - \frac{1}{3}$ M $2 - \frac{1}{3}$ F 7. Age (In yrs. last birthday) $\frac{1}{3}$ If Under 1 Year If Under 24 Hrs. $\frac{1}{3}$ Months Days Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreig http:/	
Director		Usual Residence of Decedent	8. Date of Birth (Month, Day Jul 8,	1907		PA	
Mo		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit	
Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-1 show many injury or other traumatic event, the Medical Examinar must be notified at once.	ţō	MD Washington Hagerstown			:	1 ⊠Yes 2 □ N	
r 28a	Director	10e. Street and Number 10f. Zip Code	1	0g. Citize	n of What Cour	ntry?	
3a o	<u>E</u>	115 Jonathan Street Apt. 407 21740			USA		
	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14.	Race - Americ		
a du	/Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	noari, oto.)	S	Black, White, etc. Specify: White		
Exc		3 □ Widowed 4 □ Divorced Year or Dates:			Specify. WITLE		
gica	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Give kind of work done during most of working)	ng	16b. Kind	of Business/In	dustry	
N S	ш	Elementary/Secondary (0-12) College (1-4or 5+) 11 College (1-4or 5+) Owner		F	Restaura	ant	
n,		17. Father's Name (First, Middle, Last) 18. Mother's Name	(First Middle			arre	
9 4 6	Be		Carson		,,,,,		
matic	٦ و	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		City or T	own State 7ir	Codel	
trau		Mary F. Punt wife 115 Jonathan St. Ap					
other		20a, Method of Disposition 20b. Place of Disposition (Name of D			tion - City or To		
7 0 7		1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State	0.000	0.	. 1		
injur.		*4 □Donation 5 □ Other (Specify) Bethel Church Cem. Apr 1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gro	2,2006	caso reov	cade, M	ID 1 Home T	
any ir		Reaulte M. More 50 S. Broad St. W.					
		23a. Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.			11 1/20	Approximate Interval Between	
physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
attending physics as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		230	23d. Date of delivery Month Day Yea		
ped:	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown					
should be detached	þ	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use es 2 🗆 f		he cause of death?	
page 2 sho	Completed		24a. Was a autops perform	SV.	prior to co death?	ppsy findings availab impletion of cause of	
rector, pag	Be (25. Was case referred to medical axaminer?	(Check only or	Θ)			
dire	일	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA Cther: 4 ☐ Nursing Hon	ne 5 🗆 Reside	ence 6	Other (Specif	(y)	
e funera		27. Manner of Death 17. Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? M 1 Yes 2 No	28d. Describe h	ow injury a	ccurred		
d in by the f	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route N City or Town, State)				
completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the co	ause(s) an ate and pl	d manner as s ace, and due to	tated. o the cause(s)	
complet	M	29b. Signature and title of certifier 29c. License number	2	9d. Date s	igned (Month,	Day, Year)	
		V - 3 2 19 00055994	1	4.1	0.00	0	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
		lisa Higgins bothym 1110 Medical Campus Rd.	Hagerst	.own,	MD 217	742	
Sta		APR 1 8 2006 32. Registrar's Signature					
egistr	ar	APR 1 8 2006 Steeler 1. 18 April 1					

			1 - For State Registrar	State of Ma	aryland		artmer	nt of H				iene	006	12391		
	Physic	ian	Decedent's Name (First, Middle, Laborothy	E.	Oueer	n					2. Date of Deat April 12,		Year	3. Time of Death		
	/Medi Exami		4a. Facility Name (If not institution, gir				4b. City	, Town, or	Location of		1p1 11 12,		ounty of Dear	10:45 A M		
	LAGITII	, e	Prince George's Gener					verlv					ice Geor			
8.7	Funeral	-310	Social Security Number 6.		e (In yrs. ia	st birthday)		r 1 Year	If Under 2	4 Hrs.	8. Date of Birth (Month, Day, eb. 12,	Yearl	9. Bird	thplace (State or Foreign		
Appr D	Director —		577-36-0031 Usual Residence of Decedent	IC M AXIF	78	Yrs.					eb. 12,	1928	Was	shington, DC		
land	Mo		10a. State 10b. County		10c. City,	Town or Lo	cation		,					10d. Inside City Limits		
Man	He de	ţ	Maryland Prince (eorge's	Capi	itol He	ights							1 □ Yes 2XX No		
th the	or 28a-f ahow te notified at	Director	10e. Street and Number				10f. Zi	p Code			11	0g. Citize	n of What Co	ountry?		
ath wi	23a	ral	4907 Addison Road	#104				207	43				USA			
sr de	Iteme I e r r	Funeral	11. Marital Status	12. Was Decedent I		13.	Was Dece If Yes, spe	dent of H ecify Cuba	ispanic Origi n, M exican,	in? (Spec Puerto F	ofy Yes or No- lican, etc.)	14	nican Indian, e, etc.			
336 Irs at	P		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X2XN If Yes, Give Year or Dates:	NO		1 🗌 Yes	2 No	Specity:			S	Specify: Black			
5-0 72 Po	natura lical E	Completed by	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usu	al Occup	ation	- f		16b. Kind	6b. Kind of Business/Industry			
Maryland 21215-0036	s fand 2 should be filed within 72 hours axar death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f ahow other traumatic event, its Medical Everal at must be notified at	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT u	ise retired	during most ()	or workin	9					
12 X			10 17. Father's Name (First, Middle, Last	1		Home	naker		10 14-45-4	- NI	(F:	In Home Maiden Sumame)				
and d be f		Be c	Julian Edwin Mov								_	,				
shout	mark mark	ို	19a. Informant's Name/Relationship			19b. Mailir	ng Address	s (Street a		Molli or Rural	e Toney Route Number,		own State 2	Zin Code)		
	Health ar tem 27 is other trau		Dee Tyner / Niece								lains, Ma					
ore,	Item rotts		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Na.	me of	- 1	Da	_		tion - City or			
Baltimore,	ant: M ant: M ury o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			-			ery 04	4/17/2	2006	Land	lover, M	aryland		
Sait	Department of Hes Important: If Item any injury or otba once.		21. Signature Africa Service Lice	nsee /		22	. Name a	nd Addres	s of Facility	Geor	ge P. Kal	as Fu	neral H	ome PA		
ш <u>а</u> с	2 E E G		flye !!	(0)			o100 0	xon H	ill Road	d Oxo	n Hill, M	aryla	nd 2074	45		
/N	ysician Medical aminer		23a. Part 1. Exter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a	<u> </u>	ANCE	R		9, 3001. 03 02		Tospiratory arre			Approximate Interval Between Onset and Death		
8760, <->sate be executed	hysicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.													
O. Box 6	by the attending p ached for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome of pregnancy 1							230	ivery Day Year				
S, P.	gned eb ec	b	Part II. Other significant conditions	ontributing to death bu	ıt not result	ing in the ur	nderlying o	ause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?		
ord	been sk	ted					_				1 Te	s 2 🗆 N	lo 3□Pri	obably 4 Unknown		
Vital Records, elcian: The law requires t	has Je 2	Completed	_								24a. Was ar autopsy perform	ed?	prior to death?	topsy findings available completion of cause of		
E E	certificate irector, paç	BeC	25. Was case referred to medical						26. Place o	of Death	Check only one	No No	1 🗆 Yes	2 No		
of Vita Physician:	this ce al dire	일	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatier		R/Outpatien	t 3 🗆 DC	OA Cthe	r: 4 🗆 Nurs	ing Hom	e 5 🗌 Residei	nce 6	Other (Spec	cify)		
□ ₽	fter	ë ë	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 2	8b. Time of Injury		28c. Injury Work	at ?	28	d. Describe ho	w injury o	ccurred			
VISION Attending	oealli. Stor: After r the funer	cat	2 Accident investigatio		44 5	- (-	М		′es 2 □ No		(2)					
Division of Attending	Direct In by	Certification:	4 Homicide determined	28e. Place of Inju building, etc	. (Specify)	ie, iarm, stre	eet, factory	y, office		28	City or Town,		umber or Hu	ral Route Number,		
DIVISIO • Hospital or Attendi	To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one) Certifying Property (Check only one)	ysician: To the best on the basis of and manner state.	examinatio	ledge, death on and/or inv	occurred	at the tim	e, date and printed in the determinant of the deter	place, ar	d due to the ca I at the time, da	use(s) an te and pla	d manner as ace, and due	stated. to the cause(s)		
To the	To 11	M	29b. Signature and title of contilier					c. License					igned (Monti			
)			101				,	D5	8186	5		4-	12-	06		
	-/		30. Name and address of person who DONALD	GEORGE		3001	Print) Hos-	PITA	L DX	2	CHE	VER	LY, A	06 1D 20185		
	Sta Registr	_	31. Date filed (Month Pay, Year) APR 1 8 21	37 Aegistra	r's Signatu	ге	all D						,	7		

DHMH 17 Rev 1/2001

ORIGINAL

		-	For Sitate Registrar	ate of Maryla		artment of He <i>rtificate of L</i>			ene g. No.	16	1239	
4	•		Decedent's Name (First, Middle, Last)					2. Date of Death	1	Var	3. Time of D	eath
	Physicia		Warre	n Tennis R	iffle			April	12 2	2006	0745	АМ
	/Medid Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	of Death					
		и.	SunBridge Care Cen	ter		E1kton			Cec			
	Funeral		5. Social Security Number 6. Sex	2 T E	. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT 10,	orth ay, Year) 9. Birthplace (Sta Country) West Vir			-oreign
	Director		235-20-8950 La La La La La La La La La La La La La	84	175.			OCT 10,	1921	West	Virgin	.1a
	land ow	1	10a. State 10b. County	10c. C	ity, Town or L	ocation	-			1	0d. tnside City	Limits
	Mary 1 eh	ţō	Maryland Cecil	- j	North E	last					1 TYes 2	□No
	r 28e	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Coun	try?	
	th with	a D	520 South Main Street	t, Apartmer	it 312	21901			Unite	ed Sta	ites	
	ems ems	Funeral Director	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- Rican, etc.)		ce - Americ		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or Items 23a or 28e-1 ehow ont, the Medical Exarcant rout to codified at	by Fu		I ∐ Yes 2 ∭ No If Yes, Give		1 ☐ Yes 2 📉 No	Specify:		Specif	y: 1.71_		
Ö	hour turel	d be	15. Decedent's Education	Year or Dates:	16a Dece	edent's Usual Decupa	ntion		I6h Kind of B	White Business/Industry		
5	in 72	Completed	(Specify only highest grade con	mpleted)	(Give	kind of work done d DO NOT use retired;	furing most of wor)	king		•		
212	l with piene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Tir	ning Coil	er		Stee	1		
פ	be do do	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	laiden Sumai	ne)		
Maryland 21215-0036		To E	John E. Riffle				Mary	E. Clark				
an	2 should and Mer is marke eumetic	111	19a. Informant's Name/Relationship (Type, I		19b. Mail	ing Address (Street a	and Number or Ru	ral Route Number,	City or Town	, State, Zip	Code)	
	is 1 and 2 of Health a Item 27 is other tree		Nancy J. Riffle/Wi			S. Main St						
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Remo	ovar from State		osition (Name of matory or other place	1 1	1 13,	West C	Cheste	er,	
Ë	tmen tent:		' 4 ☐ Donation 5 ☐ Other (Specify)	R.		is & Co. Inc			Pennsy	lvani	.a	
Bal	Depa Impo eny ir		21. Signature of Funeral Service Licensee	11.0	H	2. Name and Addres icks Home 03 W. Sto	for Fun	erals, P.	Α.	(1 <i>-</i>	210	0.1
			23a. Part1. Enter the disease, or complication	ons that caused the de						агута	Approximate	
	Alexander.		shock, or heart failure. List only one ca Immediate Cause (Final	ause on each line.							Interval Betwee	ath
	/Medical		disease or condition resulting in death) a	Due to (or a la conse	equence of):	preum	oug.			-	unkn	any
В	Examiner			Due to for as a conse	itio d	Alzheim	ers Typ	e		-	lenkn lenkn	WL
-	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of).	7 0	- Of					
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D (_		
,097	ate be executed nysician and he burial-transit		resulting in deathy East	Due to (or as a conse	iquence or):							
687	physi the b	dical	d.							-		
9	certif iding ise at											
X		/Me		If yes, outcome of preg					23d. Da	ate of delive	ery	
Вох	death certificate a attending phy d for use as the	ician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	tal death 3	□Ectopic pregnancy			1	ate of delive	ery Day Ye	ar
ó	t the death by the atter ached for u	hysician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fe	tal death 3				1		,	ar
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		1 - For State Registrar	State	of Ma	aryland	-	artment ortificate			ınd M	ental Hy	gien Reg. N	UUU.	12393
Physi	ician	1. Decedent's Name (First, Mi Virginia Mae									2. Date of De Month	ath D	ay Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institu	tion, give street and				4b. City, To	own, or I	Location of		March 3		_2006 c. County of Dea	10:35 p **
		10810 White R		7.47	//= /=	ne bimb day)	Potoma If Under 1		if Under 2	24 Hrs	O Data of Bin		lontgome	*
Funera Directo		5. Social Security Number 470–20–1961	6. Sex 1 ☐ M 2/0X		32 (III yrs. 12.	st birthday) Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 01/05/1	y, Yea	r) C	thplace (State or Foreign ountry) nesota
P		Usual Residence of Decedent	-		10. Ch	Town and a					0170072		7 11211	
ahoy ed at	ō		gomery		Potor	Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N 28a-f	Director	10e. Street and Number	Bomol y		10201		10f. Zip C	ode				10g. C	Citizen of What C	
h with	0		m Drive				2085	54			10	Jnit	ed Stat	es
r deat	Funeral	11. Marital Status	Armed	Forces?	Ever in U.S	. 13.			spanic Orig	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race - Am- Black, Whi	erican Indian,
LING X 1X 13-0030 be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f ehow event, the Medical Exeminer must be natified at	by Fi	1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divore	Married 1 🗍 Y	Give Or Dates:	10		1 □ Yes 2 ⊑	No No	Specify:		Specify: W	hite		
2 hou	ted	15. Dece	dent's Education	_			dent's Usual (of working	20	16b.	Kind of Business	Vindustry
ithin 7	Completed	Elementary/Secondary (0-1	thest grade complet 2) Collec	e (1-4or 5		life.	DO NOT use	retired)	uring most	OI WOIKII	<i>'</i> 9	Dom	1.4	
Hygier Ther th	Ö		lle. Last)	5±		Bank	Office	-	18. Mother	r's Name	(First, Middle		nking	
id be id ental liked o	To Be	George Edgar B									istina			
2 should I and Men I e marke	1	19a. Informant's Name/Relati	onship (Type, Print)			19b. Mailir	ng Address (S	Street a	nd Number	r or Rura	l Route Numb	er, City	or Town, State,	Zip Code)
and 2 and 2 m 27	1	William Robert	son/Son						e Roa		Accokee		MD 2060	
Pages 1 ment of Hi ant: If Iter		20a. Method of Disposition 1 Burial 2 Cremati		om State	Cel	metery, crer	sition (Name matory or other	er place					Location - City or entwood,	
perfullible; Intellible perfuse the filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural", or Items 23a or 28a-f ehow any Injury of other traumatic event, the Medical Examinet must be notified at	où.	*4 □ Donation 5 □ Othe 21. Signature of Funeral Serv		1 1	//	22	2. Name and	Address	s of Facility	1040	Rocks	111	e Tike.	Rockville.
permit Deputi Imports any Inju	됩	en vom	Dush-	Prea	ell	Ma	rylan	d, 2	20852	Simp	ole Tri d Crema	but	e Funer	al
		23a. Part1. Enter the disease shock, or heart failure.	or complications the	at caused on each lin	the death.	Do not ent	er the mode	of dying	, such as o	cardiac oi	r respiratory a	rrest,		Approximate Interval Between Onset and Death
Physicia		Immediate Cause (Final disease or condition resulting in death)					orrhage	e						11 days
/Medica Examine	_				a conseque									
	je je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Aneurysm Rupture Due to (or as a consequence of):											11 days	
acuted ind transl	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			n in l									82 years
or ou, cate be executed ohysician and the burial-transit	ie Ü	resulting in dealth, East	Due	to (or as	a conseque	ence or);								
ificate g phys	edicai		d											
th cert	M/me	IF FEMALE: 23b. Was decedent pregnant			of pregnan		Ectopic preg	gnancy				Щ	23d. Date of de	livery Day Year
The Coli d3, T.O. DOX 00100, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burral-translt	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		egnant at nknown	time of dea		Other (spec					- 1	MORT	Day Fail
that the odd by			ditions contributing	o death bu	ut not resul	ting in the u	nderlying cau	ıse give	n in Part I.		23e. Did t	obacco	use contribute t	o the cause of death?
w requires to been signed should be a	ed by										10	Yes	2 🛣No 3 🗆 P	robably 4 🗆 Unknown
law re as be	Completed	Hyperlipidemi	S								24a. Was	osv	prior to	utopsy findings available completion of cause of
hysiclan: The law his certificate has t											perfo 1 ☐ Yes	rmed? 2 X IN		s 2□No
vital siclan: certifica irector, p	o Be		Hospital:	□ le setie	- a -	D/Outpation	nt 3□ DOA	Othe	6		(Check only o		6 MOther (Co.	
n = a	1115		28a. D	Inpatie ate of Injur Month, Day		28b. Time o Injury		c. Injury Work	4 🗀 1401		28d. Describe		6 ☐Other (Spe jury occurred	ecity)
Attending Ph or death. ector: After th by the funeral	atio	1 X Natural 5 Per 2 Accident inv	estigation	nonin, bay	7 7 5417	піцагу	М		es 2□N	No				
or Att or Att after d Direct in by	ertification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide det	arminad 288. P	lace of Injudicities of the contract of the co	ury - At hon c. <i>(Specify)</i>	ne, farm, str	reet, factory, o	office		2	28f. Location (City or To			iural Route Number,
spital	C	3737	fying Physician: To	the best of	of my know	rledge, deat	h occurred at	the time	e, date and	d place, a	and due to the	cause((s) and manner a	s stated.
To the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	one)	cal Examiner: On the	e basis of nanner sta	examination	on and/or in	vestigation, ir	n my op	inion, deat	th occurre	ed at the time,	date a	nd place, and du	e to the cause(s)
To t To t	Σ	29b. Signature and title of cer	^	inske	, Q				number				ate signed (Mon	
14		20 Name and addings of	0		0	23a) /T) 19	759			Apr	il 4, 20	006
		30. Name and address of personal Sandra J. Gin						# 5	06 Wa	ashin	igton.	DC	20036	
	State	31. Date filed (Month, Day, Yo	par) 3	2 Registra	ar's Signati	JIFO ASS	artes	<u>,, , , , , , , , , , , , , , , , , , ,</u>			-O - OIL		-4000	
Regi	strar	APR	5 2006	STAN STAN	والر م	17								

State of Maryland / Department of Health and Mental Hygiene 0 0

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Lou Ella	Masser.
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			1 - State Registrar		20	Cen	tificate	of L	Death			Reg	. No.				
			1. Decedent's Name (First, Middle,	Last)		2. D.							Day	Vane	3. Time o	of Death	
П	Physici /Medic		LOU ELLA RUS	SELL							April	($\operatorname{DI}^{a_{y}}$	2006	2:50	Рм	
1	Examin		4a. Fecility Name (If not institution,		er)		4b. City, To			of Death			4c. County				
			8179 Ethan Driv	e		Easton							Talbot				
	Funeral		5. Social Security Number 6	. Sex 7	Age (In yrs. last bi		If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of (Month.	Birth Day, Y	ear)	9. Birthp	lace (State	or Foreign	
	Director		501-26-4587	1 □ M 2 L 2 L 2 L	74	Yrs. SEPT						19,	^{ea} 1931	N. D	ÄKOTA		
	D >		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or loc	ation							1	0d. Inside (Dis. Limite	
	anyla •ho	-			Too. Oily, Town	m or Loc								Ι'		•	
	8a-f	Directo		LBOT			EAST					1 ☐ Yes 2 🛣 No					
	er death with the Marylan Itams 23a or 28a-f ehow Included by Davillish at	吉	10e. Street and Number	-		10f. Zip Code 21601						10g. Citizen of What Country?					
	ath v	ra	8179 ETHAN AVI										USA				
	er de Itam	Funeral	11. Marital Status	12. Was Decede Armed Force 1 ☐ Yes 2[ent Ever in U.S. es?	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican								e - Americ ck, White,			
5	rs aft	by F	1 ☐ Never Married 2 ☐ Marrier 3 🏋 Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 No Specify:							Specif	WHI	TE		
215-0036	72 hours after death with the Maryland natural', or itame 23a or 28e-f ehow disal Examinet meet be modified at		15. Decedent's			16a. Decedent's Usual Occupation							b. Kind of B	usiness/Inc	dustry		
ر 15	n n	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4d	or 5.1)	(Give k	ind of work O NOT use	done d retired)	luring mos)	t of worki	ing				,		
7	d within giene. rr than "	Completed	12	2	JI 3+)	MAS	TER G	RDI	ENER				NURS	ERY			
ğ	othe	BeC	17. Father's Name (First, Middle, La	ist)					18. Mothe	er's Name	e (First, Midd	die, Ma	iden Surnan	ne)			
<u>a</u>	uld by Aenta rked tic e	TOE	ANTHONY WILSON	Ŋ					MA	BEL	NYBLU	M					
Maryland	Shou and M		19a. Informant's Name/Relationship	(Type, Print)							al Route Nur				Code)		
	and 2 alth alth 27 i		DRAKE G. RUSSELI	L, SR./SON		3382	BASF	ORD	ROAD	, FR	EDERI	CK,	MD 21	703			
e e	es 1 an of Heal f Item 2 r other		20a. Method of Disposition	CDameual from Sta	20b. Place o	of Dispos	ition (Name atory or oth	of er place	9)		Date	20	c. Location	City or To	wn, State		
Ĕ			1 ☐ Burial 2 🙀 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		CHESA	PEAK	E CRE	TAM!	CON C	TR 4	/4/200	06 \$	STEVEN	SVILI	E, MD)	
Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lie	censee	000	22	Name and	Addres	s of Facilit	NBET	N _E ŠST	EWN/	M FUN	ERAL	HOME	PA	
<u> </u>	207 2 9		Joseph M.	Ustrousk	CF.SR									90I			
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus nly one cause on each	h line								_		Approxima Interval Be	tween	
ì	Physician		Immediate Cause (Final disease or condition	Hupart	terrine	AH	LLIOS	cle	whi	· Ca	white	as	ewar	PAGS	Onset and	Death	
	/Medical		resulting in death)	Due to (or	as a consequence												
	Examiner **		Sequentially list conditions.	b													
	ps tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence	of):											
	certificate be executed ding physicien and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to /or	25 2 000500110000	sequence of):											
ဋ္ဌ	cien cien		,	Due to (or	as a consequence	uence of):											
09/89	physic the	/Medical		d							-				· · · · -		
ŏ	ding se a	/Me	IF FEMALE:	23c. If yes, outcor	me of pregnancy								224 00	te of delive			
n		clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death		Ectopic pred						230. Da		Day	Year	
л. Э.	the d y the ched	Physicia	1 □ Yes 2 □ No 9 SUnknown	9□ Unknowr		-	Ottroi (apoc					_					
	law requires that the death as been signed by the etter 2 should be detached for u	百	Part II. Other significant condition	s contributing to death	h but not resulting i	in the un	derlying cau	se give	n in Part I.		23e. Di	id toba	co use cont	ribute to th	e cause of	death?	
g	uires sigr ld be	d by									1 (□ Yes	2 No	3 Prob	ably 4 □	Unknown	
Ö	w require been sis	ete									24a. W	ac an	24h	Were auto	psy findings	available	
ě	⊕ - ⊕	Completed									au pe	itopsy erforme	d? .	prior to cor death?	npletion of	cause of	
Vital Hecords,	ilcian: Th certificate rector, pag		25. Was case referred to medical								1 X Ye		No /	Yes	2 No		
		o Be	examiner?	Hospital:	atient 2 ER/O	utnations	3□ DOA	Othe	-		n <i>(Check on)</i> me 5 □ Re		~50	(0 4			
DIVISION OF	Phys er this eral di); To	27. Manner of Death	28a. Date of I	njury 28b.	Time of		: Injury Work			28d. Describ		A	er (Specify red	at s	cene	
<u></u>	Attending I r death. actor: Aller by the funer	to	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	м		? ∕es 2 🔲	No							
<u> </u>	Atter	III C	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of	Injury - At home, fa	arm, stre	et, factory,	office			28f. Location			er or Rura	l Route Nur	nber.	
בֿ	s afte	Certification;	4 Hollicae	bullaing,	etc. (Specify)						City or	rown, s	state)				
	o Hospital or Atten 24 hours after deal Funeral Diractor: etely filled in by the		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the be caminer: On the basis and manner	est of my knowledg	e, death	occurred at	the tim	e, date an	d place,	and due to the	he cau	se(s) and ma	nner as st	ated.	(a)	
	the Hos in 24 ho the Fun ipletely	edical		and manner	stated.	ioror invi	estigation, if	і ту ор	enion, dea	un occurr	ed at the tim					5)	
	To the within 2 To the complet	Σ	29b. Signature and the of certifier		11		29c. I		number	-			. Date signe				
			XVIA	vx/	V ((O.C.M	. Ŀ.		Ar	ril O	z , 20	U6		
	10-		30. Name and address of person w	2	of death (Item 23a)		,										
			21 Date filed (Heath Day Vacil	Clar Posi	intrarie Cian-tura	111	Penn	Sti	eet,	Bal	timore	2, N	laryla	nd 21	201		
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 20	06 Regi	istrar's Signature	Lan	20										
			711 11 U T 20	1													

			State of Maryland	/ Depa	rtment of Health and M	ental Hygie		12395				
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last) Emmeline Bailey Rumbley 4a. Facility Name (If not institution, give street and number) 103-H Sunshine Court		4b. City, Town, or Location of Death Forest Hill	2. Date of Death Month March 31	Day Yeer 2006 4c. County of Death Harfo	rd				
	Funeral Director		5. Social Security Number 579 − 24 − 7924 Usual Residence of Decedent 6. Sex 1 □ M 2 □ F	Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 18,	^{9. Birth} Co. 1925 Sout	nplace (State or Foreign untry) n Carolina				
3	th the Maryland or 28a-f show s netified at	irector	10a. State 10b. County 10c. City, To MD Harford 10e. Street and Number	own or Loc	Forest Hill	_	. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No untry?				
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or itama 23a or 28a-f show svent, the Medical Exartinal must be natified at	by Funeral Director	103-H Sunshine Court 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		21050 Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto f ☐ Yes 2 ▼ No Specify:		Black, White	Race - American Indian, Black, White, etc.				
Maryland 21215-0036	s filed within 72 hou I Hygiene. other than "natura rent, the Medical E	Completed		_	ent's Usual Occupation kind of work done during most of workit O NOT use retired) LSCal clerk	ng 16	b. Kind of Business/I	Business/Industry				
aryiana	D 9 2 3	To Be C	17. Father's Name (First, Middle, Last) Rolla Andrew Bailey	9b. Mailin	18. Mother's Name (First, Middle, Maiden Surname) Frances Kennedy lling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Baltimore, Ma	1 and 2 Health a sm 27 is		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	of Dispos etery, crem	I Sunshine Court, Sition (Name of atory or other place) Memorial Park 4	ate 20	c. Location - City or 1					
Baltil	permit. Pages Department of I Important: If its any injury or of		21. Signature Aduneral Service Albensee	22. 70	Name and Address of Facility The	omas Fune bridge, N						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	411	C CANCER	7	,	Interval Between Opiset and Death				
,097	te be executed ysician and le burial-transit	dical Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as a consequence conse									
O. BOX 68	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death	Ectopic pregnancy Other (specify)		23d. Date of delive Month	rery Day Year					
ecords, P.	The faw requires that ite has been signed by age 2 should be deta	ρχ	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause given in Part I.	23e. Did tobac	2 No 3 Pro	the cause of death? bably 4 Dunknown				
итан жес		e Completed	25. Was case referred to medical		26. Place of Death	24a. Was an autopsy performed 1 Yes 2 (Check only one)	d? prior to co	opsy findings available ompletion of cause of				
Sion of V	ding Phy	ation; To B		Outpatient D. Time of Injury	3 DOA Other: 4 Nursing Hon		e 6 Other (Specinjury occurred	ify)				
DIVIS	i Cit	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	8f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,				
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Gertlfying Physician: To the best of my knowled to the best of my knowled and manner stated.	lge, death and/or inv	estigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)				
	To the within To the Comple		29b. Sig ature and title of central College on D	-	29c. License number 23/775	A	PRIL 3 Ross	206				
	Sta Registr		30. Name and address of person who completed cause of death (Item 23: 31. Date filled (Month, Day, Year) 32. Registrar's Signature)	1-ALLSTON,	mare	ZLAND	21047				

			1 - For State Registrar	State	of Ma	aryland .		artmen rtificat				lental Hyg ғ	giene	006	12390)
ı	Dhusisi		Decedent's Name (First, Middle	e, Last)								2. Date of Dea Month	ith Day	Year	3. Time of Death	
	Physici /Medio		Viola May Robi	nson								April	7	2006	1404 ^M	1
	Examir		4a. Facility Name (If not institution	n, give street and n	ımber)			4b. City,	Town, or	Location	of Death		4c. County of Death			
			Chester River		+				stert					ent		
	Funeral Director		5. Social Security Number 212–78–0384	6. Sex 1 ☐ M 2 🖾 F	7. Age	(In yrs. last	birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day April 2	, Year)	Cou	pplace (State or Foreigi Intry) yland	n
	pu >		Usual Residence of Decedent 10a. State 10b. County			10c. City. T	'oum or Lo	antion							404 Inside Obstinite	_
	show	5													10d. Inside City Limits 1 ☐ Yes 2 🕅 No	
	786-f	Director	Maryland Queen	Anne		Ce	entre	ville					10- 0%-			_
	deeth with the Maryland ms 23a or 28e-1 show rmust be notified at	급						10f. Zip						n of What Co	untry?	
	ns 23	era	210 Murphy Road	12. Was De	redent F	ver in II S	13 1		L617	enanic Ori	igin? (Sn	acify Vas or No-	U.S.	A . . Race - Amer	ican Indian	_
III. III. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan artiment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural, or items 23a or 28e-f show injury or other traumatic event, the Musical Examinar must be notified at a		by Funeral	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed F	orces? 2X N ive		ł	f Yes, spe		Specify:		ecify Yes or No- Rican, etc.)		Black, White		
ş	2 hou		15. Decedent			1	6a. Dece	ient's Usu	al Occupa	ıtion			16b. Kind	of Business/l		_
<u>.</u>	7 nin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed College			(Give	kind of wo DO NOT u	ork done d se retired	<i>furing</i> mos	t of work	ing			,	
-	d with	E	12	College	(1-401-5	**	hom	emake	er				own	home		
and	be filed stal Hygi od other event, I	BeC	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	e (First, Middle,	Maiden Si	umame)		
	2 should be and Mental is marked c	10	Harry Biggers							Hass	ie B	urton Bi	lgger	S		
<u>a</u>	2 sho and is mu		19a. Informant's Name/Relations	hip (Type, Print)			19b. Mailir	ng Address	(Street a	ind Numbe	er or Run	al Route Numbe	r, City or 1	Гоwп, State, Z	ip Code)	
e,	end ealth m 27 ner tr			erfield/	dau		-	0 Mui	2 2	Road		ntrevil1				
0	or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from	State	1	etery, crer	natory or o	other place	· 1		Date	20c. Loca	ition - City or 1	own, State	
altimor	Pa tmen tsnt: jury		4 Donation 5 Other (S	pecify)		Gree		ro Ce				2/06	Greer	isboro,	Maryland	
o o	permit. Pages. Department of h Important: if ite any injury or of once.		21. Signature of Funeral Service	C Flz	yl		F1	eegle Box	and	He1	fenb	ein Fune	eral	Home,	PA.	
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that only one cause on	caused each lin	the death. [Do not ent	er the mod	de of dying	, such as	cardiac	or respiratory are	est,		Approximate Interval Between Onset and Death	
-	/Medical		disease or condition resulting in death)	a	lorasa	consequen	ce of): -	6 0	1 011	الكر	DX.	<) 1 \		-	acuh	_
	Examiner				C	erom	a A	rti	D	ner	nece				VENO	
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a	consequen	ce of):	-							12.45	
	cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events c.													
Ç	e exe	Ä	resulting in death) Last	Due to	(or as a	consequen	ce of):									
0/0/	ate b hysic the bu	dicai		d.												_
D		Me	IF FEMALE:	1								280) 6	1			
XOC	Attending Physicien: The law requires that the death certificated and call. ector: After this certificate has been signed by the attending to the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		birth :	2 🗌 Fetal de	ath 3□	Ectopic p					230	d. Date of delivers	very Day Year	
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐ Preg		time of death	n 5[Other (sp	secify)						buy roa	
	thet the		Part II. Other significant condition	ns contributing to	death bu	t not resultin	a in the w	nderlying c	ause nive	n in Part I		23e. Did to	bacco use	contribute to	the cause of death?	-
Š	signe d be	d by	NI	4			9		g., r		•		es 2 🗆 I			1
cords,	w requir been s should	ete		/								-				
Ď	sicien: The law s certificate has t lirector, page 2 s	Completed										24a. Was a autops perfor	Sy	prior to co death?	opsy findings available ompletion of cause of	9
NI G	n: Th ficate or, pa	ပိ	25. Was case referred to medical				_		-			1 🗆 Yes	2 No	1 🗆 Yes	2 No	
5	sicie certi irecto	o Be	examiner?	Hospital	Inpatie	1 2	/Outpatien	t 3 DC	Othe	r		Check only or		70		-
5	y Phy ar this eral o	-	27. Manner of Death	28a. Date	of Injur	y 28	b. Time of		28c. Injury Work	4 🗆 140		me 5 Resid			iry)	-
SICIL	nding th. :: Afte	ig ig	1 Natural 5 ☐ Pendin 2 Accident investig	9	nth, Day	rear)	Injury	м		? ′es 2 🔲	No					
	after dez after dez Directo d in by th	ertification;	3 Suicide 6 Could r 4 Homicide determ	ined 28e. Plac	e of Inju ling, etc	ry - At home . (Specify)	, farm, str	eet, factor	y, office			28f. Location (S City or Town		Vumber or Rui	al Route Number,	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physicien: To the Examiner: On the and ma	basis of	examination	dge, death and/or inv	occurred restigation	at the tim , in my op	e, date an inion, dea	d place, th occurr	and due to the c	ause(s) ar late and pl	nd manner as lace, and due	stated. to the cause(s)	
	o the	Me.	29b. Signature and title of ce title	Y	ora	-		290	c. License	number		- 2	9d. Date s	signed (Month	Day, Year)	_
	->-0		X SA	XIm	~				02	60	5	\downarrow				
			30. Name and address of person	who completed cau	se of de	ath (Item 23	a) (Type.	Erint)	7		1	C11	ir.	da	2/620	
			Parricu	Sing	NA	m	/6	20.	SPE	41	Md	621	Van	M	2/620	
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registra	r's Signature)	No.								
	Registr	ar	W			A.o	A. C.	. N.								

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 31, 2006 7: DO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Thomas Nursing Center Hyattsville Georges Prince Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year 5. Social Security 7. Age (In. s. last birthday) **Funeral** Days Hours 1 □ M 2 5 F 579-76-4209 Director Usual Residence of Decedent death with the Maryland works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 le marked other than "naturel", or Items 23e or 28e-f shov treumatic event. Its Medical Examinat must be notified at Prince 1 XYes 2 No Directo Huattsville MDGeorges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? aSalle Road USA 20788 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1X Never Married 2 ☐ Married ☐Yes 2 No Yes, Give Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: ģ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortent: if item 27 le marked other than "injury or other treumatic event. It is Mediniury or other treumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LINKHOWN unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PG Area Agency on Aging
6420 Allentown Road Camp Springs, MD 20748
ace of Disposition (Name of
metaley crematory of other place)

Date

20c. Location - City or Town, State 19a. Informant's Name/Relationship (Type Print)

Rosemary Mason Person Rosemary Mason 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Importent: If any injury or Chesapeake Crematory April 5, 2006 Beltsville, MD
22. Name and Address of Facility Montgomery. Cheatham Funeral Service 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Montgomery - Cheatham

23. Part 1. Open the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.D. Box 388 Upper Marlboro, MD 20773 Approximate Interval Between Onset and Death Immediate Cause (Final Physician scah 7.00 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): physician Box 68760 99 Physician/Medicai as the l IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DUX0815 1 ☐ Yes 2 🔭 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 🗌 Yes 2 🗆 No Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4M Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) within 2 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) 9609 aman 50 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3503 Perry Street, Suite B-Mt. Rainier, MD 20712 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 APR 05 Registrar

Physician

/Medical

Examiner

Funeral

Director

7. Age (In vrs. last birthday)

90

9. Birthplace (State or Foreign

10d. Inside City Limits 1X Yes 2 □ No

Approximate Interval Between Onset and Death

NEW JERSEY

Reg. No.

2006

4c. County of Death

TALBOT

USA

14. Race - American Indian, Black, White, etc.

Specify: WHITE

23d. Date of delivery

29d. Date signed (Month, Day, Year)

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

2. Date of Death

FEB 11 1916

APRIL

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

1□ M **X**□ F

29270 CORBIN PARKWAY

ERICKA STAGG

5. Social Security Number

152-10-5676

4b. City. Town, or Location of Death

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month_Day)

EASTON

8:45AM M

iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mantal Hyolene.	mportant: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic ayant. It a Modical Examine must be notified at
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hodisine.

ERIKA STAGG

Box 68760

P.O.

Division of Vital Records,

Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Director EASTON MD TALBOT 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 29270 CORBIN PARKWAY 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: <u>^</u> 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BERTHA L. JOHANNSES CHRISTIAN ERICKSON ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29270 CORBIN PARKWAY, EASTON, MARYLAND 21601 WILLIAM STAGG/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it, any injury or o 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 4/3/2006 STEVENSVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementic **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 D No 1 🗌 Yes CN 34a. Was an OSTODUS 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 212 No Cther: 2 1 🗌 Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation rector: by the 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) á after 4 - Homicide within 24 hours after To the Funaral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

APR 0 4 2006

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI



29c. License number

D46820

State of Maryland / Department of Health and Mental Hygiene Amended, 31,TCHB = For State 04/07/06,sbb Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Saunders, Jr. Unberto Davensceno 10:08 April 4.2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Dorchester General Hospital Cambridge If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 및 M 2 □ F Months Days Hours 28 Md. Director 213-90-0475 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "neturel", or iteme 23a or 28e-f show Medical Examinar must be notified at 1 Yes 2 No Director Md. Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Greenwood ave 21613 IISA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 2 📆 No Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 941 Willow Construction 10 construction laborer other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked of Be Laura Denise Wongus Saunders, Sr. Unberto Davensceno ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other tree 207 Gold Rush in Hurlock, Md. 21643 Laura D. Jones / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. 4/7/06 Dover, De. Capitol Crematory 4 Donation 5 ☐ Other (Specify) 21. Signatur / Funeral Service Licens 22. Name and Address of Facility Bennie Smith Funeral Home 426 E. Dover st. Easton, Md. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMOCYSTIS Physician JIROVECI PNEUMONIA /Medical Due to (or as a consequence of): Examiner b. SEVERE MUNOSUPPRESSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit HUMAN IMMUNODEFICIENCY VIRUS INFECTION Due to (or as a consequence of): Box 68760. physician by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2X No 1 🗌 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one: 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No after death 6 Could not be 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a To the Funerel C filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number D 63649 KWIYA, NO 1041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMBRIDGE, SAYA DKLUTYA 300 BYRNE STREET, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 7 2006

		1 - For State Registrar	State	e of Mar	yland / Dep <i>Ce</i>	artment o				jiene og. No.	16	12400
Physic	ian	Decedent's Name (First, Mide	dle, Last)						2. Date of Dea Month	Day	Yeer	3. Time of Death
/Med	ical	MARCIA RA		MONS		4b. City, Tow	n or Location	of Donth	MARCH		2006 ty of Deeth	11:49 PM
Exami	ner	4a. Facility Name (If not instituti 404 REED CREE					REVILI					
Funera		5. Social Security Number	6. Sex		In yrs. last birthday	If Under 1 Ye	ar If Unde	r 24 Hrs.	8. Date of Birth		9. Birth	plece (State or Foreign
Director		244-76-6370	1 □ M 2 🔀	^F 58	Yrs.	Months Da	ys Hours	Min.	APRIL 7	,1947		TH CAROLINA
pu *	1	Usuel Residence of Decedent 10a, State 10b, Coun	h	Τ,	10c. City, Town or L	ocation						10d. Inside City Limits
the Marylan 28a-f ehow	٥			1								1 ☐ Yes 2 No
death with the Maryland me 23a or 28a-f ehow	Director	MD QUE 10e. Street and Number	EEN ANNE		CENTREV	10f. Zip Cod	е		1	Og. Citizen o	f What Cou	untry?
ath with 23a or usi be		404 REED CREE	K FARM I	ANE		21	617				USA	
after deat	Funeral	11. Marital Status	12. Was	Decedent Ev	er in U.S. 13.			rigin? (Span, Puerto	ecify Yes or No- Rican, etc.)			ican Indian, etc.
s afte	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorce	If Yes	es 2 No s, Give		1 ☐ Yes 2 📆				Spec		HITE
13-UU30 72 hours after death with the Maryla "natural", or Itema 23a or 28a-1 ehor idical Examilinar must be nutified at	ed b		ent's Education	or Dates:	16a, Dece	dent's Usual Oc	cupation			16b. Kind of		
within 72 ene.	Completed	(Specify only high Elementary/Secondary (0-12)	est grade comple	ted) ge (1-4or 5+)	(Give	kind of work do DO NOT use re	ne during mo tired)	st of work	ing			,
V 7 5 5 -	E O	12	Come	7		OMEMAKEI	R			OWI	MOH I	<u> </u>
be filed tal Hygic d other	Be (17. Father's Name (First, Middle					18. Moth	her's Name	e (First, Middle, I	Maiden Suma	ime)	
ife, Maryland 2 8 1 and 2 should be filed f Health and Menta! Hyg Item 27 Is marked othe other traumatic event,	2	ROBERT EUGE			405 14-7				ANN MAI			5 0-4.1
Main and 2 st alth and 27 is n		19a. Informant's Name/Relation							al Route Number			
or the litem 2		RAYMOND R. SIN 20a. Method of Disposition	muns/ nu	JODAND	20b. Place of Disp	osition (Name of			NE, CENT	20c. Location		
Pages Nent of Int: If It		1 ☐ Burial 2 X Cremation 1 ☐ Donation 5 ☐ Other		rom State	CHESAPEA	matory or other KE CREMA	TION	3-21	-06	TEVENS	SVILLI	E, MD
DESILTMONT permit. Pages Department of Important: If Its any injury or or		21. Signature of Funeral Service		(F		ELFENI	BEIN				OME, P.A.
		23a. Part1. Enter the disease,	or complications t	hat caused th	ne death. Do not en				CENTREY or respiratory arm		MD 2	Approximate Interval Between
Physician		shock, or heart failure. Li Immediate Cause (Final	st only one cause	on each line.	ant	0,00	100)				Onset and Death
/Medical		disease or condition resulting in death)	a	e to lor as a	consequence of):	Cov	Cegz				-	D W
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p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a	consequence of):							
and I-tran	Examiner	that initiated events resulting in death) Last	c	e to (or as a	consequence of):							
/ou,	70			- 10 (-1 40 41								
BOX 66/60, eath certificate be executed attending physician and for use as the burial-transit	edic		0.									
ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of		⊒Ectopic pregna	IDCV				ate of deliv	
o death he atter ed for u	sicia	in the past 12 months? 1 ☐ Yes 2 🛣 No	4□P	regnant at tir Inknown		Other (specify				N	fonth	Day Year
d by the	Phy	9 Unknown			and samulaine in the				22a Did tol		atributa to t	the cause of death?
vequires that the deben signed by the should be detached	þ	Part II. Other significant condi	uons contributing	to death out	not resulting in the t	inderlying cause	given in Pan	11.		es 2 No	3 Pro	
cords w requires been sign should be	Completed								24a. Was a	n 24h	Were auto	opsy findings available
The law ate has b page 2 st	E C								autops	ned?	prior to co death?	empletion of cause of
VITAL MEC sicien: The law s certificate has b lirector, page 2 s	a	25. Was case referred to medic	al				26. Plac	ce of Death	1 ☐ Yes 2	2/15 No	1 🗆 Yes	2□No
Of VITA Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	1 🗌 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 N	lursing Ho	me 5 Reside	nce 6 🗆 O	ther (Speci	fy)
r g agg	ertification:	27. Manner of Death 1 ♣Natural 5 ☐ Penc	9	Date of Injury Month, Day	/ear) 28b. Time of Injury		njury at Work?		28d. Describe ho	w injury occu	irred	
Attending ar death. ector: After by the fune	licat	3 ☐ Suicide 6 ☐ Coul		Place of Injury	- At home, farm, st				28f. Location (St	reet and Num	ber or Run	al Route Number,
alor At safter d il Direct	Certif	4 Homicide deter	mined 200.	ouilding, etc.	(Specify)	, ,, ,			City or Town	n, State)		
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical (29a. Certifier 1 Cartify (Check only one) 2 Madica	al Examinar: On t	o the best of a he basis of e manner state	my knowledge, deal xamination and/or in d.	h occurred at the vestigation, in m	e time, date a ny opinion, de	and place, eath occurr	and due to the cared at the time, d	ause(s) and nate and place	nanner as s , and due t	stated. to the cause(s)
To the Within To the	₩.	29b. Signature and title of certif	ier	7	/	29c. Lic	ense number		2	9d. Date sign	ed (Month,	Day, Year)
		Constitution of the second	1		MI	DO	061321			3.	21.	.06.
10146		30. Name and address of person SEMRA SAHINC:	TMD	420 P	ENNCYI WAN	TA AVE	, CENT	REVIL	LE, MD		T	•
Si Regis	ate	31. Date filed (Month, Day, Yea	2 2 2 20 8	2. Registr	s Signature	draw.	,					

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M	Maryland / De C	partment of F e <i>rtificate of</i>			giene Reg. No.) 6	2401
	* T 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of Death
	Physic /Medi		John Thoma	ıs	Scott			Month APRIL	Day 11 2	2006	10:15 a
	Exami		4a. Facility Name (If not institution, give s		1)		or Location of Death		4c. Coun	ty of Death	
	7_1		St. Mary's Hospit			Leonar		_		. Mar	
	- Funeral		5. Social Security Number 6. Sex 1503-28-8179	M 2□F 7. A	Age (In yrs. last birthda 7 E Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	v. Year)	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent		75 Yrs.			12-2-1	930	Sou	th Dakota
	yland		10a. State 10b. County		10c. City, Town or	Location			·		10d. Inside City Limits
	Mar e-f-	to	MD St. Mary	7 's	Lexin	gton Park					1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?
	ath w	rai	21508 Amy Road			206				ed St	ates
	er de	Funerai		Was Deceden Armed Forces	nt Ever in U.S. 13	 Was Decedent of H If Yes, specify Cuba 	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Ameri ack, White,	can Indian, , etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced	1 Mary Yes 2 ☐ If Yes, Give Year or Dates		1 ☐ Yes 2 € No	Specify:		Spec	ify:	
õ	2 hou	be	15. Decedent's Educ	ation	16a. Dec	cedent's Usual Occup	pation		16b. Kind of I		ite
215	hin 7 Bo "n Mad	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	life	ve kind of work done DO NOT use retired	during most of work d)	ing			•
21	od wit	5	12			-Commissio	ned Offi	cer	U.S	. Nav	у
p	tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			me)	
Z _a	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "naturel", or Items 23a or 28e-f show aumatic event, the Modical Examinar must be notified at	2	Oliver Hood Scott					E. Eding			
Maryland 21215-0036	d 2 st th and 7 le n traun	1	19a. Informant's Name/Relationship (Type	e, Printj		iling Address (Street Schemeche			. ,		,
	teal teal		Owen Scott/Son 20a. Method of Disposition		20b. Place of Dis	position (Name of		Date	20c. Location		
Baltimore,	permit. Pages I Department of H Important: If ite any injury or ot once.		1 ☐ Burial 2 🖬 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	e cemetery, ci	ematory or other plac e1d→Echo1s		~2006			
量	mit. Pa partmen cortant: injury		21. Signature of Funeral Service License	θ		22. Name and Addre					
ñ	Departimon traporations in sonce.		Edward N. Brinsfie	ld, Jr.		22955 Holl					
10	¥,x		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that cause	ed the death. Do not e						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Han	rearbic	Romin	atory 1	ailure	2		Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequence of):	100		MICHIE			
	Examiner	L	Sequentially list conditions, b		monra.						
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):						
	xecut and	Examiner	that initiated events cresulting in death) Last	Due to (of a	s a consequence of):						
8760,	cale be executed physician and the burial-transit	dicai E	L.	. 0							
9	ificate g phy as the	edic									
P.O. Box	h cert endin	Physician/Me	230. Was decedent pregnant	Sc. If yes, outcom		Oc.,			23d. D	ate of deliv	ery
В.	deat of for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			□Ectopic pregnancy □ Other (specify) _	<i>'</i>		М	lonth	Day Year
ο.	et the d by the etach	Phys	9 Unknown								
	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as		Part II. Other significant conditions con	ributing to death	1010		en in Part I.				he cause of death?
SCOTT	requi	eted	110 3010Ke WI	~ (1)	1 remi	parcis		1 L Y	es 2 No	3 X Prot	oabiy 4 □Unknown
SC Sec	e law	Completed by	memia H	10 his	n proce	rute er	zyne	24a. Was a autops	SV	Were auto	ppsy findings available impletion of cause of
AS al F	ucian: The lav certificete has rector, page 2				4			perform 1 Yes	meg? 2⊠No	1 Yes	₹ No
THOMAS SCOTT of Vital Records,	Physician: this cartific ral director.	Be	25. Was case referred to medical examiner? 1 Yes	ospital:		ent 30 DOA Oth	26. Place of Death				
	ding Phys n. After this funeral di	7: 70	27. Manner of Death	28a. Date of Inj (Month, D		of 28c. Injur	4 🗆 Nuising No	me 5 Residence 128d. Describe he			у)
JOHN	eath. or: After the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	a <i>y Year)</i> Injury		k? Yes 2 □ No		,		
JOHN Division	Attendi er death. ector: A by the fu	iffica	3 Suicide 6 Could not be determined	28e. Place of Ir	njury - At home, farm, s	street, factory, office		28f. Location (S	treet and Num	ber or Rura	al Route Number,
2	rs after or all Dir	Certification;		Duilding, 8	etc. (Specify)			City or Tow	n, Jidie)		
4+1	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medical Examin	er: On the basis	t of my knowledge, da of examination and/or	ath occurred at the tri	re, date and place, pinion, death occurr	and due to the c	auca(c) and m	and due to	tated.
B	the P thin 24 the F mplete	Medicai	Unity .	and manner s	tated.						
	o t wit		29b. Signature and title of certifier	2	2m	29c. Licens	o <i>S</i> 1 7 3		9d. Date signi کا کا		
		18	20 Name and address of	and and and and	don'th (It == 00 : 7		031/3	0 0	7 , 14	, 20	U.6
			30. Name and address of person who cor KAE AUNG HOLLYW		CAL CENTER		37 HOLLYW	OOD MD	20636		
	Sta	ite	31. Date filed (Month Day, Year) APR 1 2 200	32 Regist	trar's Signature	1 44					
	Registr		APR 1 2 200	D William	w 15 A	No. of Line					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** KASTURBEN 12, KANUBHAI SAVALIA APRIL 3:30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 102 PEACHLEAF COURT LA PLATA CHARLES Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🗓 F Yrs 052-66-6030 73 Director MAR.19,1933 INDIA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 No MARYLAND CHARLES LA PLATA Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 102 PEACHLEAF COURT or items 23a 20646 death v INDIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiane. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo þ Specify: ASIAN INDIAN 3X Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) 7 HOMEMAKER OWN HOME marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I in: If item 27 is marked o BHIMJIBHAI TARPARA KABVIBEN DHONGA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RASIK K. SAVALIA-SON 102 PEACHLEAF CT., LA PLATA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Depertment of h 1 ☐ Burial 2 ☐ Permoval from State 4 ☐ Donation 5 ☐ Other (Specify) ō Important: If eny injury or once. LEE FUNERAL CREMATORY 4-13-06 CLINTON, MARYLAND 21. Signature of Fureral Service Licensee 22. Name and Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20046 tenter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner RTHRILIS RHEUMATOID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit pue resulting in death) Last Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical es the IF FEMALE: nse 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day ō in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the all 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMIC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autops, performed: certificate 1 ☐ Yes 2 ☐ No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 📉 No Other: 4 Nursing Home S Residence 6 Other (Specify) 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel [TE Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Light Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HENDIN9 D.44436 address of person who completed ca 102 PAULMELLON CT WALDORF MD 20602

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April 1, Day 2006 Year Kathy Lynn Smith 7:30 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4400 Olando Lane Bowie Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Feb 10, If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 🔀 F 45 579-96-8605 Director Yrs. 1961 Washington DC Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits the Medical Exerviner must be notified at Director 1 ☑ Yes 2 ☐ No Maryland Prince George's Bowie 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 4400 Olando Lane 20716 Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ò Completed by 1 ☐ Yes 2X No Specify "neturel", 3 ☐ Widowed 4 ☐ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Student Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Be 2 James E. Smith Elizabeth V. Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Elizabeth Smith (Mother) 1302 Oates Street, Chapel Oaks, MD 20743 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
eny injury or otl
once. 1 XBurial 2 Cremation 3 Removal from State MD Veteran's Cem. ` 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2006 Cheltenham, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Latimore Funeral Services, P.A. 6906 Kent Town Drive, Landover MD 20785 unore 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ZUVe /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death ed by the a detached f 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Severe Mental Retardation 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \[\subseteq \text{Yes} \quad 2 \[\subseteq \text{No} \] 24a. Was an director, page 2 autopsy performed? 1 Yes 2 1 NO Be (25. Was case referred to medical 26. Place of Death (Check only one. Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Certification: To 1 Yes 2 100 3☐ DOA After t 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No the 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospitel Within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 039550 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4850 Forbes Blow Lanham, Md 20706 Hay George Car. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Alma т. Shepherd March 25. 13:35 P. 2006 /Medical 4c. County of Death Prince George's 4a. Facility Name (If not institution, give street and number) 4b. Cily, Town, or Location of Death **Examiner** Cheverly Prince George's Hospital Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months 1 M 2XXF 80 579-22-9619 Yrs. Director South Carolina July 10, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir then "natural", or items 23s or 28s-f show the Medical Examiner must be positied at 10d. Inside City Limits Landover Maryland | Prince George's 1XXYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 U.S.A. 1401 Bellehaven Drive death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: Black Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 is marked other the any injury or other traumatic event, Item 2008. Food Tester Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Orrie Taylor Lean Barr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401. Bellehaven Drive Landover, Maryland 20785 Mr. Joseph E. Taylor (Cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ∰Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery April 6, 2006 Arlington, Virginia 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hint Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ω PD /Medical Due to (or as a consequence of): Examiner Lung Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Dementia Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2▼▼to autopsy performed? 2 XXV0 1 Yes 2√No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the dause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANALD GEORGE 3001 31. Date filed (Month, Day, Year) State APR 0 4 2006 Registrar

			State of Maryland / De State of Maryland / De Registrar	
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 9.21 PM
7	/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	Exami	ner	THE JOHNS HOPKINS HOSPITAL	Baltimore City
	Funeral		5. Social Security Number 6. Sax 7. Age (In yrs. last birthda 2 1 9 − 3 6 − 4 9 5 2 1 M 2 □ F 77 Yrs.	
	Director		,,	Months Days Hours Min. S. Date of Birth (Month, Day, Year) Nov. 28, 1928 9. Birthplace (State or Foreign Country) Maryland
	land		Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location 10d. Inside City Limits
	Mary -fehc	ō	Md. Frederick S	Sabillasville 1□Yes 2☑No
	death with the Maryland ime 23a or 28a-f ehow it must be notified at	Funeral Director	10e. Street and Number 16856 Skunk Hollow Rd.	10f. Zip Code 10g. Citizen of What Country? U.S.A
36	s 1 and 2 should be filed within 72 hours atter death with the Marylar if Health and Mental Hyglene. Item 27 is marked other than "netural", or itame 23a or 28a-f ehow other traumatic event, the Medical Examiner must be notified at	by Funera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Wes 2 No If Yes, Give 50-55 Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 hou ene. then "neturs he Medical E	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	ocedent's Usual Occupation ive kind of work done during most of working e. DO NOT use retired) 16b. Kind of Business/Industry
	filed wi Hygien other th	S		Maintenance Health Dept.
Maryland	ould be fi I Mental H harked ott	To Be	17. Father's Name (First, Middle, Last) Alvey Rosco Smith	18. Mother's Name (First, Middle, Maiden Sumame) Melzena Grace Wolfe
- 10	and 2 sh lealth and m 27 ie m		Bessie V. Smith (Wife) 1685	ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 66 Skunk Hollow Rd. Sabillasville, Md. 21780
Baltimore	0		1 XBurial 2 Cremation 3 Removal from State cemetery, co	sposition (Name of crematory or other place) L Cemetery April 10, 20c. Location - City or Town, State Cascade, Md.
Balt	permit. Pag Department Important: I any njury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility J.L. Davis Funeral Home Smithsburg, Md. 21783
	Physician /Medical Examiner purish reavel	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsi: Due to (or as a consequence of): Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
s, P.O. Box 68760	The law requires that the death centiticate be executed the hes been signed by the ettending physicien and age 2 should be detached for use as the burial-transit	by Physician/Medical I		3 Ectopic pregnancy 5 Other (specify) a underlying cause given in Part 1. 23d. Date of delivery Month Day Year 23d. Date of delivery Month Day Year
cords	w require been sig should b	Completed t		1 Yes 2 No 3 Probably 4 Nnknown 24a. Was an 24b. Were autopsy lindings avaitable
		е Сош	25. Was case referred to medical	24a. Was an autopsy lindings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
Ē	Physician: this certificatal director,	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 X inpatient 2 ☐ ER/Outpati	26. Place of Death Check only one
on of	Jing Atter fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	e of 28c. Injury at 28d. Describe how injury occurred
Division	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: Atter completely tilled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	ne Hospita 24 hours ne Funera netely tille	edicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de: Check only one) Certifying Physician: To the best of my knowledge, de: 2 Medical Examiner: On the basis of examination and/or and manner stated.	path occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			MD MD	RES-000 April 5 2006
	0		30. Name and address of person who completed cause of death (Item 23a) (Type DOSA) SARMA 600 NORTH WOLF	e, Print)
	Sta Registr		31. Date liled (Month, Day, Year) 32. Registrar's Signature APR 1 8 2006	

			For State Registrar			Marylar				ealth a Death	ind M		Reg. No.	000)	2406
, P	hysici	1000	1. Decedent's Name	e (First, Middle, Las TW: TUR		 R						2. Date of De Month	Day		ear	3. Time of Death
	/Medic Examin		4a. Facility Name (/					4b. City	, Town, or	Location of	f Death	PINE		ounty of (Oblo Death	70-00
	A. F.		UNIVERSIT						TIMO							
	uneral rector		5. Social Security N 219-40-4	296	ex 7 ★ M 2□F	. Age (In yrs.	last birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Da FEB. 12	y, Year)		Birthpla Countr IARYI	ce (State or Foreign y) AND
land	MO W		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation							100	d. Inside City Limits
e Man	infied	ctor	MD	QUEEN A	NNE		CENTRI	EVILL	E							1XYes 2□No
with th	sa or 26 the no	Dire	10e. Street and Nur 213 WIN	mber DSOR AVEN	UE			10f. Zi	Code 216]	١7			10g. Citize	n of Wha	it Countr	y?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	ural, or items 2: L'Exeminer mus	d by Funeral Director	11. Marital Status 1 Never Marri 3 Widowed		12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No		If Yes, spe 1 ☐ Yes	ecify Cuba 2 X No	n, Mexican, Specify:	gin? (Spe , Puerto	cify Yes or No Rican, etc.)	S	pecify:	√hite, et	c. LE
15- 172 t	"nat	olete		15. Decedent's Ed	de completed)		16a. Dece (Give	dent's Usu kind of wi DO NOT (ork done d	during most	of workii	ng	16b. Kind	of Busin	ess/Indu	stry
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Maryland nd 2 should be file	27 is n traun			ame/Relationship (NE P. TUR		E		-				l Route Numbe	-			iode)
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Baltir permit. F Departme	Importar any injur once.			prerat Service Licer		V ,	FI	2. Name a	nd Addres S , HEI	s of Facility	EIN 8		M FUN	ERAL	ном	Œ, P.A.
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œ ₽	ate has page 2	Completed									_	24a. Was autor perfo 1 Yes	rmed?	deat	th?	y findings available pletion of cause of
08	this certific ral director,	To Be	25. Was case referexaminer?	,	Hospital: 1 10 In	patient 2	ER/Outpatier	nt 3 🗆 D	OA Othe			(Check only only only only only only only only		7Other (Speciful	
n of	fler		27. Manner of Deat 1 DNatural 2 Accident		28a. Date of (Month		28b. Time o Injury		28c. Injury Work	_	2	28d. Describe I			Specily)	
Division of all or Attending Phy after death.	Director	Certification:	3 Suicide 4 Homicide	6 Could not b determined	28e. Place of	of Injury - At h g, etc. (Speci	ome, farm, st fy)	reet, facto	y, office			28f. Location (City or Tox		Number o	or Rural I	Route Number,
Division To the Hospital or Attendi	To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)	1 Certifying Ph	ysician: To the to niner: On the bas and manne	sis of examina	owledge, deat ation and/or in	h occurred	at the time, in my op	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and p	nd manne lace, and	er as stat due to ti	ed. he cause(s)
To th within	To th comp	Me	29b. Signature and	Nitle of Certifier				29	c. License				29d. Date	signed (A	Aonth, Da	ay, Year)
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		,	1 - State of Maryland	/ Depa		łealth ar	nd Mental Hy		006	12407
			Decedent's Name (First, Middle, Last)				2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		Lyle E. Tatum				April		006	6:20 P M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of [Death	4c.	County of Death)
			Friends Nursing Home		Sandy Sp				ntgomer	
	Funeral Director		5. Social Security Number 481-05-8097 Usual Residence of Decedent		If Under 1 Year Months Days		Min. 8. Date of Bi (Month, D) Oct 26	th ay, Year) 5, 19	18 Iow	nplace (State or Foreign intry) a
	land ow	1	10a. State 10b. County 10c. City, 1	fown or Lo	ecation					10d. Inside City Limits
	Mary f sh	ţō	Maryland Montgomery Sandy	y Spr	ing					1 ☐ Yes 2 X No
	r 28s	irec	10e. Street and Number		10f. Zip Code			10g. Citi	zen of What Cou	untry?
	th wil	aip	17340 Quaker Lane #117		20860			USA		
980	d within 72 hours after death with the Maryland Jene. r than "natural", or itams 23a or 28e-f show the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 █️No	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: Who	, etc.
21215-0036	within 72 ho ene. than "natur ne Medicel	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired istrator	pation during most of d)	f working	Pea	nd of Business/I ce/Socia ion Grou	al '
Maryland 2	be file ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Last) Elmer Elwood Tatum			18. Mother's	Name (First, Middle Grover	_		
lary	2 shoul and M is marl aumati		19a. Informant's Name/Relationship (Type, Print)	19b. Maifir	ng Address (Street	and Number	or Rural Route Numb	per, City or	Town, State, Zi	ip Code)
Baltimore, M	l and lealth om 27 her tr	1183	20a. Method of Disposition 20b. Plac	e of Dispo etery, crer	Pennacool sition (Name of matory or other plac ke Cremat	ce) A	Columbia, April 5, 2006	20c. Lo	1045 cation - City or T tsville,	
Baltir	permit. Pages: Depintment of H Important: If Ite any injury or of		21. Signature of Funeral Service Licensee Powers Thanks MC125	, Ĝ	Name and Addre	ss of Facility	ition Serv	ice	P.O. Bo	
	Prysician /Medical Examiner	iner	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Do not ent					6	Approximate Interval Batween Onset and Death Question Onset Application Onset App
,0928	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent d.	nce of):	= =					
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Division of	al or Attending s after death. It Diractor: Attention by the tune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location City or To	(Street and wn, State)	d Number or Rui	ral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely tilled in by the	edical	29a. Certifier Check only one) Certifying Physicien: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or in	vestigation, in my o	pinion, death	place, and due to the occurred at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier Log Ali Chay	M	D 29c. Licens	e number	323		signed (Month), $14,200$	
	J _m	te	30. Name and address of person who completed cause of death (Item 23 31. Date fifed (Month, Day, Year) 32. Legistrar's Signature	Rid	ge Ro	e OF	COLUN	KH	AND	21044
	Registr	- 27	APR 0 5 2006	By	neti					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Edith L. Tyler March 26 2006 2240 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF 211-16-7670 81 Director Aug. 15, 1924 Pennsylvania Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examiner must be mutified at 1 X Yes 2 ☐ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 14400 Homecrest Road 20906 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Madical Examina one. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 📉 No δ 3 ☐Widowed 4 ☐ Divorced Specify: American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Administrator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marcellus M. Lloyd, Sr. Lorena E. Bagby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcellus A. Lloyd, Jr./Brother 6705 Lindbergh Blvd., Philadelphia, PA 19142 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1)∑Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 4 Donation 5 Dother (Specify) 4/1/2006 Brentwood, MD 22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) YPAIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.O. I 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 Yes 2 110 1 ☐ Yes 2 ☐ No : After this certifica e funeral director, p Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 Yes 2 No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death admitted at the lime, date and place, and due to the name as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 28, 2006 30. Name a address of person who completed call of death (Item 23a) (Type, Print) Exercise Blue 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar APR 0 4 2006

Amend items: 20b & c.per F.H.G-854 4/20/06 reb & 20a. le.

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Physic /Medi		1. Decedent's Name (First, Middle, Last John Robert	Townsend					2. Date of De Month MARCH	31, 2	006	3. Time of 0	Death A ^M
Exami		4a. Facility Name (If not institution, give 3404 CURTIS DRIVE 5. Social Security Number 6. Se	# 201	last birthday)	4b. City, Towr OXON If Under 1 Ye	HILL ar If Under		8. Date of Bir	PRIN	CE GE 9. Birth		r Foreign
Funeral Director		238-70-3591 X	M 2□F 61	Yrs.	Months Day	/s Hours	Min.	8. Date of Bin (Month, Da 09/17/	71944		Carolin	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene. Deperment of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic.	Completed	15. Decedent's Elementary/Secondary (0-12)		(Give	dent's Usual Oc kind of work do DO NOT use re eaning	ne during mos ired)		g	16b. Kind of	Business/Ir		
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is 1 and 2 sho of Health and N item 27 is ma other trauma		19a. Informant's Name/Relationship (7 Norma Thompson-Har	rison/Sister	4342	ng Address (Str Vauxha	ll Road	d; Ri	chmond,	, VA 2	3234		
permit. Pages 1 ar Depertment of Hea Important: If Itam any injury or othe once.		20a. Method of Disposition □□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□□	Removal from State Rive	Place of Disponentery, con profile P	psition (Name of mators or other CHEMIT	olace) OLY Y	3/31/0	2/2006	20c. Location Riverdal Washin	i - City or T le Mary gton,	land	
permit. Depert import eny inj		21. Signature of Funeral Service Licentuck Communication (Communication) 23a. Part 1. Enter the disease, or contraction of heart failure. List only	Juenal	. 5	2. Name and Ad 801 Cle	veland	Aven	ue; Ri			.ces 20737 Approximate	
ate be executed and hysicien and the burial-transit		resulting in death) Sequentially list nor dilions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect d.	quence of):								
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The lar ate has page 2	Completed							24a. Was auto perfo 1 Yes		b. Were aut prior to co death? 1 Yes	topsy findings a ompletion of ca 2 No	available ause of
	To Be	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DOA	Other		(Check only ne 5 ☐ Res	one) idence 6 ∑C)ther (Spec	sfy) SCE	NE
Sing After	ertification; T	27. Manner of Death 1 ANatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. I	njury at Work? 1 Yes 2	2		how injury occ			
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- 7		30. Name and address of person who have the sa	uthall, ms		111 I	Penn St	reet	Balti	more, 1	Maryla	and 212	.01
S Regis	tate trar	APR 0 4 2006	32. Registrar's Sign	Ann	E							

ALISHA VENTURA	
06-02125	
RJ	4

Alisha Eufemia Ventura March 27, 2006 Year 12:35a 48. Felicin Name (Iron institutions, give street and number) 48. City, Town, or Location of Death As Felicin Name (Iron institutions, give street and number) 48. City, Town, or Location of Death Prince George 's 5. Social Security Number 6. Sec. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number 100. Social Security Number Secu		_1	For State Registrar	State of Man		artment of F			Reg. No.		2410
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To State and Number 100. City Town or Location 100. City Town or Locat			577-11-8810	¬X				(Month, Da	v. Year)	Countr	v)
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Elementary/Secondary (o.12) College (1-4or 5+) Sales Representative Simply Wireless Sales Representative	al', or items 2 yant per mul	by runera	11. Marital Status 1)∑ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give	er in U.S. 13.	Was Decedent of H If Yes, specify Cubi	fispanic Origin? (S an, Mexican, Puert		Black	, White, et	tc.
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23a. Part Letter the disease, or complications that casked the death. Do not enter the mode of dying, such as cardad or respiratory arrest, immediate Causes (Plant Indicated List only one cause of each inch. Due to (or as a consequence of): D	ant of Heel It: if item 2 y or other	-	20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other pla	ce)	Date		•	
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25. Was case referred to medical examiner? 1	be d	ਨ∣	Part II. Other significant conditions o	ontributing to death but i	not resulting in the u	inderlying cause gi	ven in Part I.	1 _			
25. Was case referred to medical examiner? 1		complete						auto perfe	psy promed? de	ior to com	pletion of cause of
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29a. Certifier (Check ority one) 29a. Certifier (Check ority one) 29a. Certifier (Check ority one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	after death. I Director: After d in by the fun	ertificatio	2 Accident investigation 3 Suicide 6 Could not b	28e. Place of Injury building, etc.	- At home, farm, st (Specify)	reet, factory, office	Yes 2 No	28f. Location (Street and Numbe	r or Rural	Route Number.
30. Frame and address of person who completed cause of death, (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201	Funer Funer stely fill		(Check only 2 Madical Exar	ninar: On the basis of ex	xamination and/or in						
Y P P A A A A A A A A	within comp	Me	29b. Signature and title of certifier	Pollod	10						
	ye.		Pilaria As		th (Item 23a) (Type	Print) 111 Pe	nn Street	t Balti	more, Ma	rylan	d 21201

				1 - State Registrar	e of Marylan		artment of H			ene 2006	2 2 months
		Physici	an	1. Decedent's Name (First, Middle, Last) Rose	Weisb	era			2. Date of Death Month March 29	Day Ve	3. Time of Death 6:45 P. M
-		/Medio Examir		4a. Facility Name (If not institution, give street ar		erg	4b. City, Town, or	Location of Death	march 2	4c. County of [
		- Adiiiii		Hebrew Home of Grea	ter Washi	ngton	Rocky				gomery
		Funeral Director		5. Social Security Number 6. Sex 577-60-3407 1□ M 25	7. Age (In yrs.		Il Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7/16/19)	Ye <i>ar)</i>	Birthplace (State or Foreign Country) New York
		land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
		Mary B-f sh	ţō	Maryland Montgomery		Rockvi	.11e				1,□Yes 2□No
		or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	
		eath v	Funeral	6121 Montrose Road 11. Marital Status 12. Was	Decedent Ever in U.	S 13	2085		cify Yes or No-	U. S.	A. American Indian,
	936	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Executer must be notified at	by Fun	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2X No s, Give or Dates:		If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F Specify:	Rican, etc.)		Vhite, etc.
	5-0	72 hou natura	Completed	15. Decedent's Education (Specify only highest grade compl	ated)	16a. Dece	dent's Usual Occupa	ation during most of working	19	6b. Kind of Busin	ess/Industry
	121	within sne. then "	mpi	Elementary/Secondary (0-12) Coll	ege (1-4or 5+) Years			during most of working		II C C	
	9	filed Hygie other ent, tr	Be Co	17. Father's Name (First, Middle, Last)	lears		Administr	18. Mother's Name	(First, Middle, M		overnment
	/lan	uld be Mental irked o	To B	Samuel Weisberg				Sadie	Kirschne	er	
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Type, Prin Jeffrey M. Laub - Neph				and Number or Rura Seed Hill			re, Zip Code) yland 21044
	ore,	of Hea		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3】☐ Removal		lace of Dispo emetery, crea	osition (Name of matory or other plac	e) D	ate 2	Dc. Location - City	y or Town, State
	ij	tant: I		'4 ☐ Donation 5 ☐ Other (Specify)	Na Na		Cremator				urch, Virginia
	Bal	permit Depar Impor any in	3 10	21. Signature of Funeral Service Licensee	tottleme	KE 1	091 Rocky	ss of Facility Sel Funera Ville Pike	Rockvi	lle. Mai	
				23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death on each line.	h. Do not en	ter the mode of dyin	g, such as cardiac of	r respiratory arres	st,	Approximate Interval Between Onset and Death
		Pnysician /Medical	βÝ	Immediate Cause (Final disease or condition resulting in death)	CEREB	PAL	11+6	20MBO	515		Onset and Death
-		Examiner		Di Di	e to (or as a consequ	uence of):					
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequ	uence of):					
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55	8760,	cate be executed physician and the burial-transit	dical Ex	d d	e to (or as a consequ	uence or):					
E	9	rtificat ng phy s as the	Medi	IF FEMALE:							
SB	D. Box	law requires that the death certific as been signed by the attending t 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	s, outcome of pregna Live birth 2 ☐ Fetal Pregnant at time of do Jnknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
W	, P.O.	uires that the signed by die detact		Part II. Other significant conditions contributing	to death but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contribu	te to the cause of death?
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2	000	law requ as been 2 should	ompieted						24a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
/IJ	E B	The ate h	Com						performe	ed? deat	
S	Vital	ysician: is certific director,	Be	25. Was case relerred to medical examiner? Hospital:			Othe	26. Place of Death	(Check only one)		
0	of	Phys or this eral dii	.: To	TEL THIS ZE NO	1 Inpatient 2 Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury	at 2	ne 5 Residen 8d. Describe how		Specify)
1×	ion	ttending P death. ctor: After i	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	<br Yes 2 □No			
	Division	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificitely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At ho building, etc. (Specify	ome, farm, str	reet, factory, office	2	281. Location (Stre City or Town,	et and Number o State)	r Rural Route Number,
		pital o		29a. Certifier 1 Certifying Physician:	o the heet of my kno	wledge deat	h accurred at the tirr	and date and place of	and due to the sou	una(s) and manna	r on stated
		To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Examiner: On	the basis of examina manner stated.	tion and/or in	vestigation, in my or	pinion, death occurre	ed at the time, dat	e and place, and	due to the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifier		\	29c. License	number	290	d. Date signed (M	_
		3		· x auca	llum)	1)00	1308	7 10	ARCH :	30,2006
				30. Name and address of person who completed	cause of death (Item	(123a) (Type)		1 TAR SE	RA L	20711	Meg MO
		Sta	4		32. Agistrar's Signa	ture	parte		7	Cour	26852
		Registr	ar	APR 05 2006	Deserve .	12. 19					

hysician	n	1. Decedent's Name (First, Middle, La. WILLIAM1	WARNE.	R			2. Date of Do Month 03	Day	3. Time of Death 2209
/Medica Examine		4a. Facility Name (If not institution, give Anne Arundle M			4b. City, Town,	or Location of Dea			of Death Ardundle Arungle
uneral rector		5. Social Security Number 6. S 214-84-0985 Usual Residence of Decedent	Sex 7. Age	e (In yrs. last birthda 2 Yrs	Months Days			rth ay, Year) 1964	9. Birthplace (State or Foreig Country) Maryland
trem 2.1 is marked other than heldral, or items 22a of 28e-1 enow other traumatic event, the Medical Exaction fourt be notified at To Re Commissed by Finansi Director		10a. State 10b. County		10c. City, Town or					10d. Inside City Limits
Director		10e. Street and Number		Easto	10f. Zip Code			10g. Citizen of V	What Country?
hy Finarai	2	29549 Golton D 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		21601 3. Was Decedent of If Yes, specify Cut	Hispanic Origin? (pan, Mexican, Pue	Specify Yes or No no Rican, etc.)	USA 14. Rac Blac Specify	e - American Indian, :k, White, etc.
Completed	paraidi	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation	(Gi	cedent's Usual Occu ive kind of work done a. DO NOT use retire	during most of wo	orking	16b. Kind of Bu	B1ack usiness/Industry
a	מ	12 17. Father's Name (First, Middle, Last)		,	Chief		me (First, Middle		
F	2	George Isaac 19a. Informant's Name/Relationship (7)	Giddens Type, Print)	19b. Ma	niling Address (Street	Pear tand Number or R		ner er, City or Town,	State, Zip Code)
1	-2	Rosella B. Campe 20a. Method of Disposition 1		20b. Place of Dis	position (Name of rematory or other pla	ice)	t, St.Mi		Maryland 21663 City or Town, State
once.		4 □ Donation 5 □ Other (Specif) 21. Signature of Fundal Service U cen	y)	Charles	Thomas 22 Bennile Adds 426 Dover	ss of Facility un	eral Hom	e	mels,Maryland
al		23a. Part1. Enter the disease, or comp shock, or hear failure. List only Immediate Cause (Final disease or condition	Davison	1					
cai Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a	a consequence of): a consequence of):	- S -				Onset and Death
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			For State Registrar	State of Ma	arylan		artmen <i>rtificat</i>			Mental Hyg	iene _{9g. No.}	106	2	3
	Dhi.		1. Decedent's Name (First, Middle, La	st)					-	2. Date of Deat Month	h Day	Year	3. Time of Deat	h
	Physic /Medi		Joseph Edward Wi	1son								2004	1903	М
)	Examir		4a. Facility Name (If not institution, giv	e street and number)	1	1	4b. City,	Town, or	Location of Dear	h	4c. Cou	unty of Death		
			PENINSULA REGIOAM	Medien	CEN	116/		51	7115647			NICOM	1100	
	Funeral		5. Social Security Number 6. S	ex 7. Ag DXM 2□F		last birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min	8. Date of Birth	Year)	9. Birth	place (State or Fore	aign
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1	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Lim	nits
5	Maryl f ehc	ō	PA Delawar	0		.lingda							1 X Yes 2 □	
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10	with Se or	۵	118 Jackson Avenu	۵			101. 2.0	1902	2	1.	US		indy:	
L	ours after death with the Marylar sal', or items 23s or 28s-f ehow Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	.S. 13.	Was Deced			Specify Yes or No-		Race - Ameri	can Indian.	
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8	ral', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	195	5	1 ☐ Yes	2XI No	Specify:		Spe	ecify:	White	
21215-0036	"natural", "natural",	Completed	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usua	al Occupa	ation	rking	16b. Kind o	of Business/In	dustry	
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2	ygier ygier t,	S	12			Mecha	nic					Burner		
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₹ Z	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	မ	Joseph C. Wilson							d Donovan				
Maryland	12 sh nand ris m		19a. Informant's Name/Relationship (Suzanne Wilson/Da							ural Route Number,			Code)	
	1 and 1eatt		20a. Method of Disposition	ugnter	20h P					llsboro,			Chat.	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marke any injury or other treumatic angles.	П	t X Burial 2 ☐ Cremation 3 🛚		1	Place of Dispo emetery, crer			I			on - City or To		
ij	it. Pa		4 ☐ Donation 3 ☐ Other (Special Control of Fundamental Service Line)		Edg				Pk. 4/5/			Mills	, PA	
Ba	permit. Depertmentimperte	1	21. Signature of Fine eral Service Cit er	300	11	Ze	ller	Fune	ral Home	e,P. O. B	ox 20	7		
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			shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	10.	0	1/	o or ayırıç	g, such as cardia	c or respiratory arre	151,		Interval Between	
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	deat te att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at			Other (spe					Month	Day Year	
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သူ	as be	Completed								24a. Was ar		b. Were auto	psy findings availal	ble
	The lay cate has page 2	mo.								autopsy perform	ed? No	death?	2 No	л
ita	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						26. Place of Dea	ath (Check only one				
of Vital	Physiclan: this certific ral director,	To I	1 Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatien	t 3 DO	A Othe	r: 4 Nursing H	lome 5 Reside	nce 6 🗆 (Other (Specif	y)	
0			27. Mainper of Death → □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	21	Bc. Injury Work	at ?	28d. Describe ho	w injury oc	curred		
Si	endin eath. or: A he fu	atle	2 Accident investigation				М		es 2 □No					
Division	irect irect	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	iry - At ho	ome, farm, str	eet, factory	, office		28f. Location (Str City or Town	eet and Nu State)	mber or Rura	I Route Number,	
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of	examinat	wledge, death tion and/or inv	occurred a	at the tim in my op	e, date and place inion, death occu	, and due to the ca	use(s) and te and plac	manner as s	ated. the cause(s)	
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		- 1	30. Name and add ss of per on who	mpleted cause of de	eath (Item	23a) (Type,	Print)	C-	1:-1	I MD	1/0	n /		
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registra	ur's Signat	// 0 / / _ ture	<u> </u>	Xu.	ISDUCY	1111	2180	//		
	Posiot		APR 95	2006		M .	ha. H	la .						

State of Maryland / Department of Health and Mental Hygiene. UUD For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 30 Z355 03 Calvin Henry Webster 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WILDMICO Keninsula Regional medical Center If Under 1 Year Months Days 8. Date of Birth (Month, Day, Y) May 2, 1 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Months Hours 1**∑**M 2□F 213-16-7572 81 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County orient: If item 27 is marked other then "naturel", or items 23a or 28a-f show injury or other traumatic event, the Madical Examinar must be notified at YYes 2 □ No Dorchester Cambridge Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ā 604 Water Street 21613 US Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Heelth and Mental Hygiene. 1 ☐ Never Married 2 💢 Married 1 ☐ Yes 2X No White Baltimore, Maryland 21215-0036 Specify: WW II Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 10 Realtor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be E. Guy Webster Lula Foxwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Heelth a Importent: If Item 27 is eny injury or other trat. 604 Water Street Cambridge, Maryland 21613 Janice N. Webster Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/3/06 Cambridge, Maryland Dorchester Mem Park 22. Name and Address of Facility
Thomas Funeral Home, P.A. bij uneral Service Licensee 21. Signature 700 Locust Street Cambridge, Maryland 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prenmonia 1-2 Wh **Physician** Nooi-Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and the for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 3 Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No 1 ☐ Yes 2 ☐ No this certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 24 t and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 03 06 D41721 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SALISBURY PAVLOS 400 E. SHORE DR. WD 21804 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Department of Health and Certificate of Death		ene 00	5 12415
	Physici	ian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Ye	3. Time of Death
	/Medi	cal	Richard Mervin Whitby	April	8 20	
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat 24910 Dukes Road Greensboro	n	4c. County of I	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Y	Caroli ₉	ne Birthplace (State or Foreign Country)
Ŀ	Director		218-48-5080 1X M 2□F 58 Yrs. Months Days Hours Min.	OCt 15 1	.947 M	Country) aryland
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d leade Challen
	Maryi	ō				10d. Inside City Limits 1X Yes 2 □ No
	ith the Marylan or 28e-f ehow	Directo	10e. Street and Number 10f. Zip Code	10g	. Citizen of Wha	t Country?
	23a c	a D	24910 Dukes Road 21639		U.S.A.	,
	tems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - A	American Indian, White, etc.
5	rs afte	by Fi		•	Specify:	White
2-0036	72 hours after death with the Maryland neturel', or items 23a or 28e-1 ehow disal Examinat must be incitified at			16	b. Kind of Busine	ess/Industry
2	within 7, ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during most of work done during m	king	b. Iting of Bushin	osa maasa y
7	filed wi Hygien other th	Con	12 waste water technicia	n D	uPont Ir	ndustry
and	be fill H	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Ma		
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<u> </u>	s 1 and 2 should be filed within 72 hours after death with if Health and Mental Hygiene. Health and Mental Hygiene thems 23a or them 27 is marked other than "neturel", or items 23a or other traumatic event. Its Medical Examination must be		C1 T 17 17 1 / 1 C			
ă,	of Health of Health of Item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of	ensboro, I	c. Location - City	
altimor	Pages nent of ant: if it ury or o		I AD DUTAL 2 LICIONIALION 3 I INOMINISTRIALI	11/06 Hi	illsboro	, Maryland
Dall	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenb PO Box 160 Greensbo			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest	,	Approximate Interval Between
j	Physician		Immediate Course (Final	ase		Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0.30		- SANOWA
	*	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
ĵ	ate be executed hysicien and the burial-transit	Еха	resulting in death) Last Due to (or as a consequence of):			
0070	cate be executed obysicien and the burial-transit	edicai	d. =			
Š	ding p	/Mec	IF FEMALE:		F	
2	atten for us	clan	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of Month	delivery Day Year
į	The law requires thet the death certific that been signed by the attending page 2 should be detached for use as it	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			,
,	uires thet signed b	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute	e to the cause of death?
Š	w require been sig should b	led t	Viabetes Mellitus	1 Tes	2□No 3□	Probably 4 Nunknown
2	hasbe	Completed	Hypertension	24a. Was an autopsy	24b. Were	autopsy findings available
= ;	the I	Con		performed	d? death	to completion of cause of 1? /es 2 \sum No
1	certifice rector, p	Be		th (Check only one)		
5 8	iding Physician: th. After this certifics funeral director, p	2		ome 5 Residence		(pecify)
5 :	ding th. : After	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Section 1 Section 28b. Time of Section 28c. Injury at Work? 2 Accident investigation M Injury	28d. Describe how i	njury occurred	
2	Atter	Ifice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree	t and Number or	Rural Route Number,
5	rs after or	Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, S.	tate)	
	Hospi 4 hou Funer lely fill	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manager stated and place, and manager stated.	and due to the cause	e(s) and manner	as stated.
	To the nospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number			
1	- 3 = 8		1 Dames - Lo- 47 D3127	-0	Date signed (Mo	
		}	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2 7	10	76
			Janger Sikes 920 Market St	5 De	uto	06 VMQ
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		.1	500 1 1 2000 M. J. J.			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend State of Maryland Pleastment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Corydon Douglas White 5.2006 /Medical April 0030 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8 Memorial Hospital Talbot **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □XM 2 □ F December 2, 1945 Mississippi Yrs. 214-46-957 Director 60 Usuel Residence of Decedent Pages 1 and 2 should be tiled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural; or Items 23a or 28a-f ehow 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at Be Completed by Funeral Director Maryland Caroline Denton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25049 Pealiguor Road 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married Specify: Caucasian 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Developmentally Elementary/Secondary (0-12) College (1-4or 5+) Case Manager Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Edmond White Leona M. Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other training once. 25049 Pealiguor Road, Denton, Maryland 21629 Ann H. White Wile 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dulanter character of the Moland rial 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 4/7/2006 4 ☐ Donation 5 ☐ Other (Specify) Gardens Cockeysville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Moore Tungral Home, P. A. Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Bladder disease or condition resulting in death) Carrinoma 15 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) tor use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 V Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. attending physicien this certificate has been After this certification tuneral director, I within 24 hours after death.

To the Funeral Director: All completely tilled in by the tu

Corydon D. White Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) APR 0 6 2006

29b. Signature and title of certifie

Idlewild Avenue 32 Registrar's Signature Deliver.

Easton, MD 21601

29c. License number

D417232

29d. Date signed (Month, Day, Year)

04/05/2006

06-02605

Please Type or Print in Black Indelible Ink Kristene Dyann Bevans State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar Physician/ Decedent's Name (First, Middle Last) 2. Date of Death Month Day April 17, 2006 Medical Examiner 0907 hrs Kristene Dyann Bevans Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 927 Garden Drive Apartment A Essex **Baltimore County** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Funeral Director Months Days Hours Foreign 217-58-6251 1 M 39 Yrs 1966^{Country)} Usual Residence of Decedent inv 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits show Yes 2 No notified at once. MD Baltimore death with the Maryland Director -28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9 927 Garden Drive Apt. 1 21221 items 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be 14. Race - American Indian, Black Armed Forces? Never Married 2 Married White, etc. Yes 2 X No permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiens [Inportant: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examineer. 4 X Divorced If Yes, Give Year Widowed Yes 2 x No specify: white Specify: 2 white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry ted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Itimore, MD 21215-0036 12 Office Manager Gen. Ship Repair 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Arthur Bevans Frances Weems ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Magyn Bevans - Daughter <u>Fernsell</u> Crt. Apt. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State 4 - 20.06Other Specify Metro Crematory <u>Baltimore</u> MD21. Signature of Funeral Service Lig 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart art I. Enter the disease, or complications that caused t **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Combined Drug (Butalbital and caffeine intoxication) Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical AMENDED item#23a,27,28a-f,perME,g856,6/16/06 TT attending physician or use as the burial -X UNPENDED O. Box 68760, JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 🗸 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è م 1 Yes 2 No 3 Probably 4 V Unknown of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available or this certificate has be ral director, page 2 sh autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other₄ ER/Outpatient 3 Nursing Home 5 Residence 6 🗸 Other: Scene 1 V Yes 28a Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: Division Natural 5 Pending 1 Yes 2 X No Fnd 4/17/2006 Fnd 9:02 am ımk 2 Investigation 28f. Location (Street and Number of Rural Route Number, City or Town, State) 927 Garden Drive, Apt A 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 ☐X Could not be 3 Suicide Essex, (Specify) Homicide at residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License numbe. 29d. Date signed (Month, Day, Year) O.C.M.E. April 18, 2006 Name and address of person who compl eted cause of death (Item 23a)

State

Registrar

Theodore King MD.

31. Date filed (Month, Day, Year), APR 2 (

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2006

istrar's Signatur

			1 - For State Registrer	State of M	laryland / [Departmer Certifica				giene Reg. No.	06	12419
- 1	Physicia	an	Decedent's Name (First, Middle, I	_ast)			D	_ 1	Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Nellie		Mae		Bro		04	16		6 1:35p. [™]
	Examin	er	4a. Facility Name (If not institution, g Gilchrist Nur			4b. City	Town, or Lo, Tows	cation of Death			nty of Death	
1					ge (In yrs. last bir	thday) If Unde		Under 24 Hrs.	8. Date of Bir			
	Funeral Director		229-50-1130 Usual Residence of Decedent	1□M 2 X)F		Yrs. Months		Hours Min.	(Month, Da)1 29	Col	place (State or Foreign intry) VA
	yland		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	ours after death with the Marylar ret' or items 23a or 28a-f show Exercities result be notified at	to	MD NA		Balt	imore					ĺ	1 XYes 2 No
	or 28	Funeral Director	10e. Street and Number		·	10f. Zi	p Code			10g. Citizen	of What Cou	untry?
	23e	ral	5 Walden Will	ow Ct.				207			J.S.A	•
	after dea or iteme	une	11. Marital Status	12. Was Decedent Armed Forces	?	13. Was Dece If Yes, spe	dent of Hispa scriy Cuban, I	anic Origin? (Spe Mexican, Puerto i	ecify Yes or No Rican, etc.))- 14. [Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married X☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give Year or Dates:		1 ☐ Yes	2 ∑ No 5	Specify:		Spe	city:	Black
Ş	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ahow the Madical Examinat riskt be nutiliad at	edt	15. Decedent's			. Decedent's Usu	ial Occupatio	n .		16b. Kind o	f Business/I	
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212	d with	Completed	3rd Grade	na na	5+)	House:	keepi	ng		Sinai	. Hos	pital
b	al Hys	Bec	17. Father's Name (First, Middle, La	st)			18	. Mother's Name	(First, Middle	, Maiden Sun	пате)	
<u>a</u>	uid b Menti arked	10	Bee Petty					Lottie	Cosby	7		
<u>8</u>	2 sho and is ma		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Addres	s (Street and	Number or Rura	i Route Numb	er, City or To	wn, State, Zi	ip Code)
2	and ealth m 27		Ann Knotts-Da	ughter				low Ct				21207
o.	or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	,	f Disposition (Na ry, crematory or	me of other place)		Date	20c. Location	on - City or T	Town, State
_	tant:		4 ☐Donation 5 ☐ Other (Spec		Woo	dlawn		4/22,	/06	Balti	more	Co, Md
$\mathcal{M}_{\mathcal{I}}$ Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 21 is marked other then "naturenty in other traumatic event, the Modical ODE.		21. Signature of Funeral Service Lic	ensee	.)	22. Name a March	F/H	West				
Spn	402.04		23a. Part1. Enter he disease, or co	5 - Fire	d the death Do			h Ave,			Md	21215 Approximate
7	Physician :		shock, or heart failure. List on trmediate Cause (Final disease or condition	ly one cause on each I	n do m	1				irest,		Interval Between Onset and Death
0	/Medical		resulting in death)	-	s a consequence							Jean
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= 8	death	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 □Ectopic p 5 □ Other (s					Month	Day Year
30	the d y the iched	lysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown								
5 g	requires that the een signed by th nould be detache	by Pt	Part II. Other significant conditions	contributing to death I	but not resulting i	n the underlying	cause given i	n Part I.	23e. Did t	obacco use c	ontribute to	the cause of death?
7 E	quire n sig uld blu								10	Yes 2 N	3 🗆 Pro	bably 4 Unknown
23	aw requ s been 2 should	Completed							24a. Was		b. Were aut	opsy findings available
$\mathcal{Z}_{\mathfrak{g}}$	The lav	E							autoj perfo	psy ormed? 2.2.No	death?	ompletion of cause of
(力量	ician: Th certificate ector, pag	Bec	25. Was case referred to medicat examiner?				20	6. Place of Death	100			- 1
	Physician: this certific ral director,	To	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpati		utpatient 3 D	OA Other:	4 Nursing Hor	me 5∐Resi	dence 6	Other (Spec	in Hospice
Division of	ding Pi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b.		28c. Injury at Work?	1	28d. Describe		curred	
<u>s</u> .	Attending r death. actor: After by the fune	Certification:	2 Accident investigat 3 Suicide 6 Could not	he		М		2 □ No				
Ž	or Ati	ŧ	4 Homicide determine	and 28e. Place of in	njury - At home, fa atc. <i>(Specify)</i>	arm, street, factor	y, office	4	28f. Location (City or To		ımber or Rui	ral Route Number,
Δ	To the Hospital or Attend within 24 hours after death To the Funarel Director: completely filled in by the		20a Cadillar 450 Cadillar	Dhusiaian Turi	A -4 4 4							
	Hospital 24 hours a Funarel itely filled	edical	29a. Certifier (Check only one) 1 Certifying in the Certific in the Cer	Physician: To the best aminer: On the basis of and manner si	of examination an	e, death occurred id/or investigation	f at the time, n, in my opini	date and place, a on, death occurre	and due to the ed at the time,	date and place	manner as ce, and due	stated. to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	A eA		29	c. License ni	umber		29d. Date sig	ned (Month	, Dey, Year)
	F 3 F ŏ			Mily	ino	1	125	205				
	~		30. Name and address of nerson wh	o completed cause of	death (Item 23a)	(Type Print)	, , ,			- /-		,
	12		30. Name and address of person wh	1 6 BM	(670	1 N.C	hard	es St	Balto	. wid	212	08
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	alle de						
	Registr	ar	APR 2 0 200	b falls	Sea Marie							

06-01878 Linda Bortner Please Type or Print in Black Indelible Ink

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2006	2420
Physician/ ledical Examiner		
	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4014 Marjeff Court Fullerton Baltimore County	
Funeral Director	5. Social Security Number 215–48–1648 6. Sex 1 Months Days Hours Min. 08/31/1945 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth	
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
Maryland 28a-f show any d at once ector	Maryland Baltimore Fullerton 1	s 2 _{XX} No
with the Maryland ms 23a or 28a-f sh be notified at once eral Director		
21215-0036 Mental Hygiene. marked other than "natural", or items 23a or 28a-f she revent, the Medical Examiner must be notified at once o Be Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.	
ours afte atural", saminer	3 Wildowed 4 Divorced in test of Divorced of Dates: Videowed 1 Yes 2 XXNo specify: Wn1	te
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examinar Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) 4+ Special Education Teacher Baltimore City	Schools
21215-0036 Juld be filed within 7 In Mental Hygiene, In marked other than ic event, the Medica TO BE COMPILE		
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other traumatic event, To Be	20a. Method of Disposition 1 Burial 2 X X Cremation 3 Removal from State 4 Donatigs 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 4/19/2006 Catonsville, M	
Balti permit. Departn Imports injury c	21. Signatury of Funeral Servic, ucensor Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, MD, 21211	
Physician /Medical xaminer	23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ope cause on each line. Approximately a such as cardiac or respiratory arrest, shock, or heart should be caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart should be caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart should be caused the death.	mate Interval n Onset and Death
Xaiiiilei	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	
ted nsit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated	
cuted nd transit	events resulting in death) Last Due to (or as a consequence of): d.	
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687 certific nding 1 ise as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
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cords, P.C. aw requires that has been signed be seen should be deta	1 Yes 2 ✓ No 3 Probably 4 24a. Was an 24b. Were autopsy findin	ngs available
of Vital Records, Ing Physician: The law requires the sentificate has been signeral director, page 2 should be n: To Be Completed	autopsy prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes 2	
of Vital Recing Physician: The After this certificate uneral director, page nr. To Be Con	25. Was case referred to medical examiner? Hospital: 1 Inspiral 2 EB/Output 2 EB/Out	
_ = ` ≃ ⊼	. 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
<u>(S</u> ≤ 5 5 5 5 1 5 1	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural Route Nor Town, State)	lumber, City
8 - 5	1 29a Centiter	
om dith is	and manner states.	
To the He within 24 To the Pr completel	29b. Signature and title street 29c. License number 29d. Date signed (Month, Day, Ye. O.C.M.E. April 14, 2006	ear)
To de within To de comp		ear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amenditen#8, perFH C854, 420/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:20 P. M **BECK** ADFLE 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL BALTIMORE-WASHINGTON MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 8/27/1918 | Birthplace (State or Foreign Months Days Hours Min. | Month Days Foreign | Country | NY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2₩F 123-12-0818 Director Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 17 is marked other then "natural", or Iteme 23s or 28s-f ellor traumatic event, the Madical Examinar must be notified at Director NASSAU WESTBURY 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 117 POST AVENUE 11590 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WHITE 1 Yes 2 No Specify "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 908.8. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **GLICHER** JENNIE WEISS ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 GREENACRE COURT - SYOSSET, NY 11791 WARREN BECK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State NEW MONTEFIORE CEM. 4 □ Doylation 5 □ Other (Specify) 04/23/2006 PINELAWN, NY tur of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MA 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). physician and s the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant etten for u 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death signed by the e 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient ٤ 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Diviatural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier MD

D

worde

Baltimore, Maryland 21215-0036

certificate be executed

Box 68760;

P.O.

Division of Vital Records.

State Registrar 31. Date filed (Month, Day, Year) APR 2 0 2006

Chroke Guirbus



30. Name an ad en of person who completed cause of death (Item 23a) (Type, Print)

06-02599 Steven William Baranovia

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygien

teven vviillam		1- For State Certificate of Registrar			_{eg_No} 200(12422
Physici ledical Exami		Socven Militan Balanovic		2. Date of Deat Month April 17, 2	Day Year	3. Time of Death 0320 hrs
		4a Facility Name (if not institution, give street and number) 4b 2951 Almondbury Drive	D. City, Town, or Location of Death Pasadena		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 216-13-4683 1 M 2 F 20 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	7	th(MM/DD/YYYY) 9 E 7/1986	
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a. State		10	0g. Citizen of What Co	10d Inside City Limits 1 Yes 2 No untry?
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiewie Hours after death with the Maryland ten 27 is marked other than "natural", or items 23a or 28a-fish tranmatic event, the Medical Examiner must be notified at once	by Funeral	1 X Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	U.S.A. 14. Race - Ame White, etc. Specify: Wh 16b. Kind of Business	
5-0036 led within 72 he Hygiene. other than "m	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ricians Helpe 18.Mother's Name	r	Contrac	ting
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medica	To Be C	Robert Thomas Baranovic, Sr. 19a Informant's Name/Relationship (Type, Print) 19b Mailing A	Vicky L	ynn Go tural Route Num	ddard ber, City or Town, Sta	
Haltimore, MD remit Pages I and 2 sho operations of Health and Important: If item 27 is injury or other tranmati		20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify 21. Signature Funeral Strice Accessee 22. National Strice Accessee		Date 18/06 J.Gonc	Baltimo e Funera	re, MD 1 Home, PA
Physician /Medical *xaminer	al Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or moury first mitiated events resulting in death). Last List only one cause on each line. Bue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	mode of dying, such as cardiac or	respiratory arre		Approximate Interval Between Onset and Death
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - trans	Physician/Medical	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Othe	death 3 Ectopic pregnar	-	23d. Date of delive Month	ry Day Year
Division of Vital Records, P.O. Esta derivation of Vital Records, P.O. But or Attending Physician: The law requires that the car and before the part of the functor. After this certificate has been signed by the led in by the functal director, page 2 should be detached.	Completed by	Part II. Other significant conditions contributing to death but not resulting in the unc		1 Yes 24a Was a autops perforr 1 Yes 2	n 24b. Were a prior to death?	utopsy findings available completion of cause of
n of Vital ling Physiciau: Affer this certif funeral director,	: To Be	25. Was case referred to medical examiner? 1 V Yes 2 No 17. Manner of Death 18. Date of Injury 18. Date of Injury 18. Date of Injury 18. Date of Injury 18. Date of Injury		Home 5 F	Residence 6 🗸 Othe	er: Scene
Division of Vital To the Hospital or Attending Physician: within 24 hours after the After this certif To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	1 Natural 5 Pending Investigation 3 Suicide 6 X Could not be determined (Specify) Found in house	AM 1 Yes 2 X No 1	ınk	treet and Number or R	ural Route Number, City
To the Hosp within 24 ho To the Fund completely fu	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated	d at the time, date and place, and on, in my opinion, death occurred at	due to the cause the time, date a	e(s) and manner as sta and place, and due to the	rted. ne cause(s)
		29b Signature and title of certifier Carol Hallan	29c. License number O.C.M.E.		April 17, 2006	onth, Day, Year)
			reet, Baltimore, MD 21201			
St	ate	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	N.			

			1 - For State Registrer	State of Ma	aryland		artmen rtificat			ınd M	-	giene Rog. No.	006	12423
	Physic /Medi			Zaymon	d	Ba	urt	let	七		2. Date of De. Month	Day	2006	3. Time of Death 5 45 P M
	Examir Funeral	ner	,	General Sex 7. Age	HOSP e (In yrs. las		If Under	Olu 1 Year	Mbi	4 Hrs.	8. Date of Bird	th	Howa 9. Birthp	ord place (State or Foreign ntry)
1 de 1	Director		042-03-8537 Usual Residence of Decedent 10a. State 10b. County	1 g M 2□ F	92 10c. City, 1	Yrs.	Months	Days	Hours	Min.	June I	9,19	13 Main	Del Od. Inside City Limits
	72 hours after death with the Maryland netural; or items 23s or 28s-1 show likel Esanin er must be multied at	by Funeral Director	Maryland Howard 10e. Street and Number 6336 Cedar Lane 11. Marital Status	#205	Ever in U.S.	13.	Was Dece	Code .044	spanic Orig	in? (Spe	cify Yes or No	U.	en of What Cour	
21215-0036	"netural", or ite	ieted by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	Armed Forces? 1 X Yes 2 N If Yes, Give Year or Dates: ducation rade completed)	WW II	16a. Dece	If Yes, special Yes Jent's Usua kind of wo	cify Cubai 2 3 No al Occupa	Specify:	, Puerto I	Rican, etc.)	5	Black, White, Specify: Whi d of Business/Inc	te
	S should be filed within and Mental Hygiene. Is marked other then "! eumatic event, the Men	Be Completed	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Las. Phillip Bartlet		+)		nessn	,	18. Mother		(First, Middle,	Maiden S	Retail	Ą
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygjene. Important: if item 27 is marked other then "netural; or items 23s or 28s-1 show enty injury or other treumatic event, its Medical Espain at must be multiple an once.	To	19a. Informant's Name/Relationship Raymond Bartlett 20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other (Speci	(Type, Print) (Son) Removal from State	20b. Plac		Whit sition (Name matory or o	e Pe	ach Pl	r or Rurai Lace	Route Numbe	bia,	Town, State, Zip Marylan ation - City or To	d 21045
Balti	Departmit. Popartmit. Importaritmit. Popartm		21. Signature of Funeral Service Lice	Jan to	4	W 5	Name an itzke 555 T	d Address Fun win	s of Facility eral H Knoll	lomes s Roa	Inc.	mbia,		nd 21045
8760,	death certificate be executed Examiner and for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, of conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a d.	tens a consequen a consequen	ive nce of):	Car	dło	my o	pat	thy			Interval Between Onset and Death
O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal de	ath 3	Ectopic pr Other (sp					23	dd. Date of delive	ry Day Year
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ā	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical Cert	29a. Certifier 1X Certifying Pl	building, etc nysicien: To the best of miner: On the basis of and manner sta	f my knowle	dge, death	occurred :	at the time in my opi	e, date and inion, death	place, ar	City or Tow nd due to the o d at the time, o	ause(s) a	nd manner as sta	ated. the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	k	~ , I	n.D.		License		31			signed (Month, I	
42	Sta Registr		30. Name and address of person who Harry Li, I 31. Date filed (Month, Day, Year)	.0780 H	icker	(Type, R	ridge .	r -	d,	Co	lumb	ias	MDE	2006

06-02501 William W. Berry

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Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last) William Wallace	Berry,	II	2. Date of Dea Month April 12, 2	ath Day Year	3. Time of Death 0000 hrs
		4a. Facility Name (if not institution, give street and number) 5179 Raynor Avenue		4b. City, Town, or Location		4c. County of Death Anne Arundel	
Funeral			rs. last birthday)		nder 24Hrs. 8 Date of Bi	rth (MM/DD/YYYY) 9. Birt	hplace (State or
Director		212 90 1023 1XM 2 F 28	Yrs.		June 2	25, 1977 Foreig	ⁿ ^{untry} Maryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. Ci	City, Town or Locati	on			10d Inside City Limits
Maryland 28a-f show any d at once.	ö		Baltimore				1 Yes 2 X No
S - 19	Director	10e. Street and Number 4106 Hollins Ferry Road		10f. Zip Code 21227		10g. Citizen of What Coun $\mathtt{U.S.}$	try?
ath with the items 23a	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Ye	s Decedent of Hispanic (es, specify Cuban, Mexic	Drigin? (Specify Yes or No can, Puerto Rican, etc.)	14 Race - Americ White, etc.	can Indian, Black,
after de al", or	by Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2X No spec		Specify: Whi	te
2 hours "natur	ted t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)) 16a. Decedent during me	t's Usual Occupation (Gi ost of working life, DO No	ve kind of work done OT use retired)	16b Kind of Business/Ir	ndustry
5-0036 led within 72 Tygiene other than '	Completed	9th	Р	Barber		Barber	Shop
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be Co	17. Father's Name (First, Middle, Last) William Berry			her's Name (First, Middle, Natalie Kel.		
212 hould b nd Men is marl	욘	19a. Informant's Name/Relationship (Type, Print)				mber, City or Town, State,	
e, MD and 2 sho Tealth and item 27 is traumati			b. Place of Disposi	ition (Name of cemetery,		1timore, Mar	•
Baltimore, permit Pages I an Department of Hee Important: If ite		1 Burial 2 Arcremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or oth ayview Co		4/19/2006	Baltimore,	Marvland
Balti bermit Departm mporta njury o		21. Signature of Funeral Service Licensee	22. N	ame and Address of Fac	Gonce Fur	neral Service	e, P.A.
Physician	-	23a. Part I. Enter the disease of complications that caused the dea	400 ath. Do not enter th	1 Ritchie H ne mode of dying, such a	ighway Balt s cardiac or respiratory arr	imore. Mary	Approximate Interval
/Medical Examiner	4	failure, List only one cause on each line Immediate Cause (Final disease a. Narcotic intoxi		ethadone)			Between Onset and Death
must be a second		or condition resulting in death) Due to (or as a consequence b.	e of):				
	Examiner	if any, leading to immediate Due to (or as a consequence cause Enter Underlying Cause	e of):			1	
ted trinsit	Exan	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence)	e of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	X unpended X amended item#1,r item# 2	perME,G854,	4/20/06 TT			
8760, ifficate bo		IF FEMALE: 23b. Was decedent pregnant in the	regnancy	- 125	ppic pregnancy	23d Date of delivery Month D	ay Year
Box 68 c death certif	sician	past 12 months? 4 Pregnant at time of 9 Unknown	death	ner (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, monar	ay real
, P.O. Box 68: res that the death certifi signed by the attending be detached for use as it	, Physic	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause given in	Part I. 23e. Did to	obacco use contribute to the	ne cause of death?
IS, P.	ted by				-	s 2 No 3 Proba	
cords, law requir has been se 2 should	ompleted				24a Was autop perfo		opsy findings available ompletion of cause of
of Vital Records ing Physician: The law requi After this certificate has been uneral director, page 2 should	C	25. Was case referred to medical		26.Place of Dea	th (Check only one)	2 No 1 Yes	2 No
f Vital Physician: or this certifical director.	ToB	examiner? 1 Ves 2 No 1 No 28a Date of Injury	ER/Outpatient			Residence 6 Other:	Scene
ision of Attending Pher tector: After the by the funeral	tion:	1 Natural 5 Pending Find (1/12/2006	28b. Time of In	1 Van 2		how injury occurred	
Division of Vital Records, pital or Attending Physician: The law requirours after death. neral Director: After this certificate has been stilled in by the funeral director, page 2 should the	ertification:	3 Suicide 6 X Could not be 28e. Place of Injury - At	t home, farm, stree	t, factory, office building,		Street and Number or Rura State) Motel 6 Root or ave Linthic	al Route Number, City
ing ing ing	O	4 Homicide determined (Specify) Found 29a. Certifier 1 Certifying Physician: To the best of my knowle	in motel ro				
To the Howithin 24 h To the Function of the Fu	edical	one) 2 Medical Examiner: On the basis of examination and manner stated					
	Σ	29b. Signature and title of certifier		29c. License numb	er	29d. Date signed (Mont April 13, 2006	h, Day, Year)
THE PULL	1	30. Name and address of person who completed gause of death (Ite	em 23a)			1 , 5, 2000	
INC.O.		Theodore King MD. Assistant Medical Examin 31. Date filed (Month, Day, Year) 32. Registrar's Signa		nn Street, Baltimor	e, MD 21201		
State 31. Date filed (Month, Day, Year) 32. Redistrar's Signature Registrar APR 2 0 2006							

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a,perFH,Inf. (854.4/24/06 TT) State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TDA **BRUNO** Year Μ. 200 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jonklin 59 HO51 osedo 110 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year, 5-9-1922 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2**XCX**F 184-12-8287 83 PENNSYLVANIA Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits the Modical Examiner must be notified a MD Director BALTIMORE ROSEDALE 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6510 LANGDALE ROAD 21237 U.S.A. 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married DIU() → ひ + むつ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: ģ Specify: 3 XWidowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASSEMBLER ELECTRONICS 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental DONATA MARINO DELAIDA (GERMAINO) 2 19a. Igromant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . permit. Pages 1 and 2 s
Department of Heelth ar
Important: If Item 27 te
eny injury or other trau 6510 LANGDALE ROAD ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) GARDENS OF FAITH CEM 4-21-2006 BALTIMORE, MD 21. Signature of Fur aral Survice Liotinsee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner em16 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ğ in the past 12 months? Day Month Year 4 Pregnant at time of death signed by the e 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete has been sig , page 2 should b Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy of Vital 1□ Yes 20 No Be funeral director 25. Was case referred to medical 26. Place of Death Check only one examiner? 2/1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No Director: 1 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours at To the Funerel D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0026560 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) square Drive Baltimore, MD 2/237 1. Jason 000 Frank 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

06-02611

Please Type or Print in Black Indelible Ink

imothy Bolling		1- For State Registrar	te of Maryland	-	artment of rtificate of		and M	lental Hy		eg. No.		12421
Physicia Medical Exami		1. Decedent's Name (First, Middle, TIMOTHY			LING				Date of Deat Month April 17, 2	Day Year		Time of Death 0936 hrs
		4a. Facility Name (if not institution, Greater Baltimore Medi	•	er)	4	tb. City, Tow Towson		tion of Death		4c. County of Baltimore		у
Funeral Director		5. Social Security Number 220–76–9062		Age (In yrs.	last birthday) 48 Yrs.	If Under 1 Months		Under 24Hrs. lours Min.		th(MM/DD/YYYY) 7-1957	Foreign	lace (State or ry) Md
any		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Locati	on					110	Od. Inside City Limits
ž .	ŗ		LTIMORE				ESSEX	ζ				Yes 2 X No
Maryla r 28a-f ed at or	Director	10e. Street and Number	CT 1	DT 40		10f. Zip Co			10	0g. Citizen of Wha	?	
with the Mary s 23a or 28a e notified at		8 CLOVERWOOD 11. Marital Status	12. Was Decede	PT 10			21221 of Hispanic	Origin? (Spe	cify Yes or No		American	Indian, Black,
or item	Funeral	1 Never Married 2 Marr	1 Yes	s? 2 X No	If Y	es, specify C	uban, Mex	cican, Puerto R		White,	etc.	
urs after tural",	ρ	3 Widowed 4 Divorced it Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: W.							WHIT ness/Indu			
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f shore other traumatic event, the Medical Examiner must be notified at once	ompleted	Elementary/Secondary (0-12)		College (1-4 or 5+) during most of working life. DO N ANIMAL CARE						FALLS	FALLS ROAD ANIMAL SHELTER	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Med	Be Co	WILLIAM J. BOLLING							First, Middle, N ETTE	Maiden Surname)	TING	S)
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ev	ပ္	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								State, Zip		
nore, MD 2 ages I and 2 shoul ent of Health and M nt: If item 27 is m		20a. Method of Disposition 1 Burial 2 Cremation	2 Pamayal from 6		Place of Disposi crematory or oth	tion (Name o			Date	20c. Location - C		
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		4 Donation 5 Other Spec	ify:	, idio	TRO CREN	1ATORY			9–2006	CATONS		
Balt permit Depart Impor injury		21. Signature of Funeral Service Li	censee		122. N	ame and Add	dress of Fa	acilityCVACI AVENUI	H/ROSEI E ROS	DALE FUNE SEDALE, M		HOME 21237
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con		of):						+	Death
an management a	Į.	Sequentially list conditions, if any, leading to immediate	b. Acute Aortic D								_	
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ecuted and transit												
60, ate be exe hysician e burial -	Medic	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? AMENDED AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day										
Box 6876(c death certificate the attending phy ed for use as the b	ian/N									Day	Year	
Box e death the atter	Physician/I	1 Yes 2 No 9 Unkno	wn 9 Unknown		5 Otr	ner (Specify)						
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 4.4 hours after death Fineral Director: After this certificate has been signed by the attending physician and ely filled in by the funeral director, page 2 should be detached for use as the burial - transi	þ	Part II. Other significant condition	s contributing to dea	ath but not r	esulting in the u	nderlying cau	use given i	n Part I.		bacco use contribu		
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed				-		-		24a Was a			sy findings available oletion of cause of
tal Recorian: The la	Som			·					perfor	med? dea	ath? / Yes	2 No
Vital hysicians this certi	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpat	ient 2 🗸	ER/Outpatient		Place of De Other	eath (Check on 4 Nursing		Residence 6	Other:	
1 Parties 2 No 1 Inpatient 2 FR/Outpatient 3 DOA St. 4 Nursing Home 5 Residence 6 Other. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 1 Yes 2 No												
Division fal or Attendius after death al Director:	ficati	2 Accident Investig	ation 28e Place of	Injury - At h	ome, farm, stree	1000		7.41	8f. Location (S	treet and Number	or Rural F	Route Number, City
Div spital o	Certification:	4 Homicide determine							or Town, St			
To the Ho within 24 I To the Fu Completely	Medical	one) 2 Medical Exami	ician: To the best of a ner:On the basis of ex and manner stated	amination a	ge, death occurr ind/or investigati	ed at the tim on, in my opi	e, date and nion, deatl	d place, and du h occurred at t	ue to the cause he time, date a	e(s) and manner as and place, and due	started to the ca	use(s)
	Σ	29b. Signature and title of certifier	alons				ense num	ber	29d. Date signed (Month, Day, Year)			
3	}	30. Name and address of person wi				troot D-1	tina a 1	MD 24224		1-10		z
St	ate	Carol Allan, MD Assis	tant Medical Exa			treet, Bal	umore, I	WID 21201				
Registrar												

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 30 A M JALK APRIL 14 2006 BRANCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/AHARBOR 405 DITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplece (State or Foreign Country) **Funeral** 100 M 2 □ F 218 32 6851 70 Director Oct. 6, 1935 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic svent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 413 Audrey Avenue 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 Nd 956—
If Yes, Give Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Automotive 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Wayne Branch Rudy Margaret Clawson ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Branch / wife 1558 Reinhardt Lane Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/17/2006 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 M01220 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CAN: LER LARYN GEAL disease or condition 5 YEARS resulting in death) /Medical Due to (or as a consequence of): Examiner 5 MONTHS ADVANCED

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LUNG CANCER Examiner The law requires that the death certificate be executed the ettending physiclen and ched for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be deteched 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 14☐Yes 2□No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performe certificate 1 Yes 2 No Hospital or Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 1 ☐ Yes № ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1. Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter deat 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funstal C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO APRIL RES 000 14,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HAMOVER ST, BALTIMORE, 31. Date filed (Month, Day, Year) 3001 MD 21225 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

APR 2 0 2006

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2006 16, John Patrick **Bradlev** 17:59 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) January 8, 1962 Birthplace (State or Foreign Country) **Funeral** Months 1XM 2□ F 44 027-36-0850 Director Florida Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location is marked other then "netural", or items 23a or 28a-f ehow sumstic event, the Medical Examinar must be codified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14201 Gate Dancer Lane 20841 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager/Traffic Engineering Services Specialist 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental H permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic ev John Lee Bradley Elizabeth Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Bradley/Wife 14201 Gate Dancer Lane, Boyds, Maryland 20841 20b. Place of Disposition (Name of cemetery, crematory or other place) April 21, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 2006 Germantown, Maryland 21. Signature of Fun Al Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. (Suc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrythmia m, rutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been si should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2☑ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 4 hours after deam.
Funeral Director: After this c ဥ 1 Inpatient 3 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Momicide ō To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D59129 16/ 2006 de M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Aaron Snyder, M.D. 32 egistrar's Signature 31. Date filed (Month, Day, Year) State APR 2 0 2006 Registrar

			for State	State of Maryland	/ Department of Health and	Mental Hygie	ne
			Registrar 1. Decedent's Name (First, Middle, Las.	")	Certificate of Death	Reg.	No. 3, Time of Death
	Physic /Medi		LILLEAN	BORNS			Day Year
1	Exami	ner	4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Location of De	_	Ac County of Death
	Funeral		5. Sodal Security Number 6. Se	x 7. Age (In yrs. la	Months Davs Hours M	rs. 8. Date of Birth	9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	90	Yrs.	MA926,	1915 VIRGINIA
	show	2	10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Limits 1 Yes 2 □ No
	after death with the Marylan or Itams 23a or 28a-f show ciner must be collined at	Funeral Director	10e. Street and Number_	1 /2	10t. Zip Code	10g.	Citizen of What Country?
	ath will	ralD	1535 TyplA	w Rd.	21218	1	18A
(O	ifter dea r itams ciner m	Fune	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 27 No	If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0036	raf.	d by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: BlAck
215-	G 69	Be Completed	15. Decedent's Edu (Specify only highest grad	cation (e completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	vorking 16b	. Kind of Business/Industry
12121	e filed with il Hygiene othar thai vant, Ital	Con	17. Father's Name (First, Middle, Last)	College (1-401-54)	NEVER WORKER	1	
Maryland	tai do do eva	To Be	Unk	M	andy HEST	ame (First, Middle, Maid	en Sumame)
Aary	2 shou and N is ma		19a. Informant's Name/Relationship (7)		19b Mailing Address (Street and Number or	Rural Route Number, Cir	or Town, State, Zip Code)
	ges 1 and 2 should it of Health and Mer If itam 27 is marks or othar traumatic		20al. Method of Disposition	20b. Pla	ce of Disposition (Name of	Date 20c	Z. March 2/8/ Location - City or Town, State
Baltimore,	Pages nent of ant: If i ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Tellioval Irolli State	G Mem HARK 4/	25/2006 B	AttimORE Md
Balt	permit. Pagi Department Important: If any Injury o		21. Signature of Funeral Service bicens	ee ()	Name and Address of Facility	mEJ, JR. F	un. Sw. PA
	N.		23a. Part 1. Enter the disease, or comp	ications/that caused the death.	Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	to Ma 21213 Approximate
N	Enysician		Immediate Cause (Final disease or condition	My DC	-	*	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to () s a conseque	nce of):		1/
į.	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	no of):	ecir	16 years
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):		
8760,	ate be execui hysician and the burial-trar			d			
9	certifica Iding pl	/Med	IF FEMALE:	3c. If yes, outcome of pregnance	NV		
Box	w requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ★No	1□Live birth 2 □Fetal d 4□Pregnant at time of dea	eath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
P.0	hat the od by th detache	Phys	9 ☐ Unknown	9☐ Unknown	ng in the underlying cause given in Part I.	OZ- Didash	
rds,	The law requires that the site has been signed by the bage 2 should be detache	d by	1	ment a	ng in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
eco	law red as bee 2 shou	plete	,			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B			00.30			performed?	death?
f Vit	Physiclan: this certificated director,	To Be	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	lospital: 1 ☐ Inpatient 2 ☐ EF	Oth	eath (Check only one) Home 5 Residence	6 Dother (Specify) Assist
o uc	fing Pt I. After th funeral	lon:	27. Manner of Death 1 → Satural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of 28c. Injury at Work?	28d. Describe how in	
Division of Vital Records,	I or Attandi after death. Director: A I in by the fu	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)		28f. Location (Street	and Number or Rural Route Number
D	oital or urs afte ral Dir illed in					City or Town, Sta	
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place an and/or investigation, in my opinion, death occ	e, and due to the cause(curred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	molule_	29c. License number		Pate signed (Month, Day, Year)
,	1		30. Name and address of person who co	. 0	D45757		19,2006
<u></u>			Matthew Mcs	Valney 494	to Eastern Are	Balt, MD	21221
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Location		
DH	MH 17 Rev 1/20	1	APR % 0 20	100 physics A	- Aller and a second		

Lillian Borns

		_	101	epartment of Health and Menta Certificate of Death	Reg. No.
	Physici		1. Decedent's Name (First, Middle, Last) Agnes E. Coulbourn	a Mc	te of Death onth Day Year 3. Time of Death onth Day 1.35 P M
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		2-56	FutureCare - Chesapeake	Arnold	Anne Arundel
2.0	Funeral Director		5. Social Security Number 218−28−9990 6. Sex 1 □ M 2 □ ★ 7. Age (In yrs. last birthe	months Days Hours Min. Feb.	te of Birth 9. Birthplace (State or Foreign Mary Tand
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of		
	Aaryla f ehov	ō		Burnie	10d. Inside City Limits 1 ☐ Yes 2 [X]No
	h with the N 3a or 28a-	al Direct	10e. Street and Number 1460 Crain Hwy. S.W.	10f. Zip Code 21061	10g. Citizen of What Country? United States
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examinar must be notified at Once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Was Decedent Ever in U.S. Armed Forces? 1 Yes Say No If Yes, Gree Year or Dates:	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, □ Yes 2 No Specify:	es or No- etc.) 14. Race - American Indian, Black, White, etc. Specify: White
15-0	in 72 ho n "natur ledical	pieted	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of working ife. DO NOT use retired)	16b. Kind of Business/Industry
212	ed with	Com	Elementary (Secondary (0-12) College (1-4or 5+)	Homemaker	Own Home
Maryland 21215-0036	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) Walter Sprucebank	18. Mother's Name (First, Martha Wi	Middle, Maiden Sumame) 11iams
Man	nd 2 sho lith and 27 le m			Mailing Address (Street and Number or Rural Route 712 Wren Way Glen Burn:	e Number, City or Town, State, Zip Code) ie, MD 21060
Baltimore,	ages 1 ar nt of Hea : If item or other		20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery,	Disposition (Name of crematory or other place) April 18	20c. Location - City or Town, State
ltin	ertmer ortant injury		4 □Donation 5 □Other (Specify) Glen HA 21. Signature of Funeral Service Licensee	Aven Mem. Pk. 2006 Kirktey Arundfoky Funera	
ä	Depermine Depermine Impo		> purchay	421 Crain Hwy. S.E. Glo	
A.	Physician /Medical			EUROENDOCRINE LUI	Onset and Death
3760, 4	ate be executed with the burial-transit of t	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of c. Due to (or as a cons):	
P.O. Box 68	Attending Phystcian: The law requires thet the death certifics reads. cleath. ector: After this certificate has been signed by the attending pt by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time ol death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date ol delivery Month Day Year
ds, P	uires thet signed b id be deta		Part II. Other significant conditions contributing to death but not resulting in the CHRONIL CASTRUCTIVE PLLIMONA	, ,	3e. Did tobacco use contribute to the cause of death? 11
Division of Vital Records,	The law requir te has been si page 2 should l	Completed by		24	ta. Was an autopsy performed? Yes 2 No
/ital	ystcian: The is certificete ha	BeC	25. Was case reterred to medical examiner?	26. Place of Death (Chec	
of o	Physta this c ral dire	ဥ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp		☐ Residence 6 ☐ Other (Specify) escribe how injury occurred
0	th. : After s funer	tion		ne of 28c. Injury at 28d. Do 2	escribe now injury occurred
Divis	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm building, etc. (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, on the basis of examination and/and manner stated.	death occurred at the time, date and place, and du or investigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
	To the within To the comp	ğ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	1		Mungi, MD	D57531	APRIL 14, 2006
	6		30. Name and address of derson who completed cause of death (Item 23a) (T	ype, Print)	o
	Sta	te	Moht Negi 2601 Veteran Hwy M 31. Date filed (Month) Day, Year) APR 2 0 2006	MANINE, MY ALLE	36,
	Regist	- 1	APR 2 0 2006 Server 18 19		

			1 - For State Registrar	State of Ma	aryland / I		ment of				giene	5 1	2431	
	Dhomis		1. Decedent's Name (First, Middle, Last)						2	. Date of Dea Month	ath Day	Vasa	3. Time of Death	_
	Physici /Medi		PEARL	COZ	ZART					04		006	11:35 AM	١
	Examir		4a. Facility Name (If not institution, give s	street and number)		4	b. City, Town	, or Location	of Death		4c. County	of Death		
			GOUD SAMARI	TAN .	1105/17	714	BALT	IMO			BAL	-T11	MORE	
П	Funeral		5. Social Security Number 6. Sex	: 7.Aga M.2√gF	(In yrs. last bi		f Under 1 Year Months Day		Min.	. Date of Birth (Month, Day	/, Year)	9. Birthpli Count	ace (State or Foreign ry)	n
	Director		246-32-8291 Usual Residence of Decedent	A	81				0.	1 25	25		NC	_
	/land		10a. State 10b. County		10c. City, Tow	n or Locat	ion					10	d. Inside City Limits	;
	Man Man	tor	MD NA		Balt	imor	е						1 Yes 2 □ No)
	or 28s	Director	10e. Street and Number				10f. Zip Code)			10g. Citizen of W	/hat Count	ry?	_
	th will	alD	4524 Northwood	Drive			2	1239			U.S	5.A.		
	ems erre	iner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was	s Decedent of	Hispanic O	rigin? (Speci	fy Yes or No-	14. Race	- America		_
98	or It	by Funeral	1 Never Married 2 Married	1 ☐ Yes XXN If Yes, Give	lo		Yes 2X N			Jan, 515.7	Specify			
8	urel',	d b	3 XWidowed 4 Divorced	Year or Dates:					, ·			DTO	ack	_
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-f show ha Medical Examinar must be redified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a	(Give kine	t's Usual Occ d of work don NOT use reti	e durina mo	st of working		16b. Kind of Bu	siness/Indi	ustry	
12	with iene. ther	omp	Elementary/Secondary (0-12)	College (1-4or 5 na				•	ticia	, ,	State (of M	aryland	
	ifiled Hygir other ent, I	Be C	17. Father's Name (First, Middle, Last)			egra	Cerea				Maiden Sumami		atyland	
Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Me	To B	James Bowell					Sara	ah Hud	dson				
ary	should I and Meni s marke umatic	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b	. Mailing A	Address (Street	et and Numi	ber or Rural F	Route Numbe	r, City or Town,	State, Zip (Code)	
			Shannon Y. Bowe	ll-Daugh	nter 4	524	North	wood	Drive	e, Ba	ltimore	e, Mo	21239)
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place o cemete	f Disposition	on (Name of ory or other p	lace)	Dat	θ	20c. Location -	City or Tov	n, State	
Ĕ	Pages ment of h ant: If ite ury or of		'4 Donation 5 Other (Specify)	omoval nom otate	King	Mem	orial	Par	k 4/2	1/06	Randall	lsto	vn, Md	
Balt	permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr once.		21. Signature of Funeral Service License	He // ())	22. N	ame and Add rch F	ress of Faci	lity est					
	40 = 0 0		Jynelle,	5 mes	/	43	00 Wa	bash	Ave,	Balt:	imore,	Md	21215	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each lin	the death. Do				s cardiac or r	espiratory arr	rest,		Approximate Interval Between Onset and Death	
-	Physician		Immediate Cause (Final disease or condition resulting in death)	UTERI	WE	CA	YU CE	R					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):								
		5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	. Due to (or as a	a consequence	of):								
	t insit	min	Cause (Disease or injury	,		- /								
Ŏ,	be executed sician and burial-transit	Examiner	that initiated events c resulting in death) Last		consequence	of):								
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	dlcal	€ d											
9	rtifica ng ph as th	led	IS SEMALE											_
XO	leath certific attending p	an/h	200. Was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth	of pregnancy 2 Fetal death	3∏Fct	topic pregnan	cv				of deliver		
9. B	ie dea the at hed fo	Physiclan/Me	in the past 12 months? 1 Yes 2 No	4□Pregnant at 9□Unknown			her (specify)				Mon	th E	ay Year	
P.0	that the de ad by the detached	Phy	9 Unknown	tribustina to donth bu			4.5-			age Bides				-
ds,	signe signe signe	by	Part II. Other significant conditions con	1 1	it not resulting ii	i trie under	riying cause g	jiven in Pari	. 1.				cause of death?	
Vital Record	w requ	Completed	11000111						!!					
3ec	e law has l	mpl								24a. Was a autops perform	IQ VS		sy findings available pletion of cause of	1
			OS Man anna referred to an disal							1 Yes	2010 1		□ No	
		o Be	25. Was case referred to medical examiner?	ospital: V Theatier	nt 2□ER/Ou	tnationt 1	2000	thor		Check only on		10 11		-
		 -	27. Manner of Death	28a. Date of Injur	y 28b. 1	Time of	28c. Inj	ury at			ence 6 Othe			_
ion	nding ath. r: Afte e fun	atloi	✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) i	njury		ork? ⊒Yes 2.⊑]No					
Division	ol or Attendi after death. I Director: A d in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street,	factory, office	9	28f		treet and Numbe	r or Rural i	Route Number,	-
	tel or A rs after el Dire ed in by	Certification:		building, atc	. (Opecny)					City or Town	i, State)			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	29a. Certifier Certifying Phys	ician: To the best of	f my knowledge	, death oc	curred at the	time, date a	nd place, and	I due to the ca	ause(s) and man	ner as stat	ed.	
	the hin 24 the F	Med	Unity)	and manner sta	led.									
	To Viti	-	29b. Signature and title of certifier	AA A				nse number	<u></u>		9d. Date signed	(Month, D		
	/		Milland	10(- 0)	-AL //4			584			PRIL	14	2006	
	5		30. Name and address of person who con	TIPLE NOW		TIAU	" STR	FFT	, RA	MITS	WE	42	201	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra		South	2 8		UN	- 1				
	Registr		APR 2 0 2008	Stormer	13.									

			For Stata Registrar	State of I	Marylan		artmen rtificate			and Me		giene Rag. No.	006	12432
	Physici	an	1. Decedent's Name (First, Middle, Las	(1)							Date of Dea Month	Day	Year	3. Time of Death
	/Media	cal	Grace C. Cramer		osl .		4h Cihi	Town or	Location o	f Dooth	04/15/			9:35 am ^M
	Examin	ier	4a. Facility Name (If not institution, give Anne Arundel Medical (θ1)		Anna			Death		4c. County of Death Anne Arundel		
	Funeral		5. Social Security Number 6. S		Age (In yrs.	last birthday)	If Under Months	1 Year	If Under 2	24 Hrs.	8. Date of Birth	(Vear)	9. Bir	thplace (State or Foreign
	Director			□м 2007 г	74	Yrs.	Months	Days	nours	Min.	B. Date of Birtl (Month, Day 01/10/1	932	Mar	yland
	and w.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl	ţō	MD		Balt	timore								1 TYYes 2 □ No
	n 72 hours after death with the Maryland "natural", or Itams 23e or 28e-f ehow valical Eval: in at must be notified at	I Director	10e. Street and Number 1147 Ward Street				10f. Zip 21:	Code 230				10g. Citiz	en of What Co USA	
	death	Funeral	11. Marital Status	12. Was Decede			Was Deced	ent of His	spanic Orig	gin? (Spec	ify Yes or No-	1	4. Race - Ame	
920	urs after al', or Ita	þ	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Force 1 Tyes 2 If Yes, Give Year or Date	XNo		lf Yes, spec 1 ☐ Yes 2		Specify:	, ruello h	ican, etc.)		Black, White Specify: W	hite
2-0	72 ho	ted	15. Decedent's Ed (Specify only highest gra			16a. Dece	dent's Usua kind of wor	l Occupa	tion uring most	of working	a	16b. Kin	d of Business	/Industry
21215-0036	d within diene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired)				T	D	t-1
12			17. Father's Name (First, Middle, Last)			Admin	ISCIA				(First, Middle,		as Bro	tners
Maryland	e d la b	To Be	Joseph Finazzo						Joseph		144		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ary.	d 2 should th and Men 7 is marka fraumatic	Ĕ	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address	(Street a			Route Numbe	r, City or	Town, State,	Zip Code)
	tra tra		Jo Anne Martin / D	aughter		6 E. C	hestnut	t	Pasad	ena, M	D 21122			
ore	iter		20a. Method of Disposition 1√□ Burial 2 □ Cremation 3 □	Removal from Sta	1 ^	lace of Dispo emetery, crer	sition (Nam natory or of	ne of ther place)	Da	ite	20c. Loc	ation - City or	Town, State
Eim	. Pages Iment of I tant: If its jury or o		* 4 Donation 5 ☐ Other (Specif	1)	Meado	wridge 1			-				dge, MD	
Baltimore,	permit. Page Department of Importent; If any Injury or once.		21. Signature of Funeral Service Licer		101378	රිසි 72	ry L. I 50 Wast	Address Kauline ningto	s of Facility En Fund On Blw	eral H	bme at M kridbe,	MP, I MD 21	NC. 075	
	rnysician /Medical Examiner		23a. Part 1. Enter the disease, or comphock, or heart faithre. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or	as a conseq	uence of):	er the mode	e of dying	, such as d	cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and of for use as the burial-transit	edical Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq									
.O. Box 6	ne death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 controls? 1 □ Yes 2 ☑ No. 9 □ Unknown		n 2∐Feta tattimerofd	Idéath 3□	Ectopic pro					23	3d. Date of de Month	livery Day Year
Φ.	se Go	þ	Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to		~	o the cause of death?
Records,	e h age	Completed									24a. Was a autop: perfor	sy ,	24b. Were as prior to death?	utopsy findings available completion of cause of
Vital		BeC	25. Was case referred to medical examiner?	3.0						of Death	Check only or	-		
of V	Physician: this certific ral director,	ဥ	1 Yes 2 No	Hospital:		ER/Outpatier		4	4 U Nui		e 5 Resid			cify)
ion	ding h. After fune	atlon:	27. Manner of Death Natural 5 Pending 2 Accident investigation		Day Year)	28b. Time of Injury	M 2	Bc. Injury Work 1 🗆 Y	at ? ′es 2.⊡N		3d. Describe h	ow injury	occurred	
Division	in the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	289. Place of	Injury - At he , etc. (Specif	ome, farm, str	eet, factory	, office		28	If. Location (S City or Tow		Number or R	ural Route Number,
	To the Hospital or Attani within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier Certifying Ph (Check only one)	ysicien: To the be niner: On the basi and manner	s of examina	wledge, deatl tion and/or in	vestigation,	in my op	inion, deat	d place, ar th occurred	d at the time, d	late and p	place, and due	e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	2	MD		29c	License D 5	number (8-	7 2	29d. Date	algned (Mont	h; Day, Year)
	12		Aimeo	completed cause		A	Print)		12-5	del	M	edi	cal	Conter
DH	Sta Registr MH 17 Rev 1/2	ar	31. Date filed (Month, Day, Year) APR 2 0	2006	istrar's Signa	A. A	and !	P						
2.1						0								

ORIGINAL

Cleavland James Christopher 1- For State

Please Type or Print in Black Indelible Ink

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State of Maryland /	Department of H	ealth and Menta	al Hygiene

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6	1.2	93	Sec. of	Low	1	(J)	-3.,

Physician/
Medical Examiner
N

		1- For State Registrar	Cert	ificate of	Death			Reg. No.	IUU	1640
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last)	Cleveland	James C	hristoph	er	2. Date of De Month April 11,	eath Day Ye		Time of Death 1225 hrs
		4a. Facility Name (if not institution, give st 263 Margate Drive	reet and number)	4k	o. City, Town, or Lo Glen Burnie	ocation of Death		4c. County Anne A		
Funeral Director		5. Social Security Number 6. Sex 216 68 9603 1 X M Usual Residence of Decedent	7. Age (In yrs. las	If Under 1 Year Months Days	If Under 24Hrs Hours Min.		Birth (MM/DD/YYY 5,1955	Count	lace (State or Foreigr ry) y land	
any		10a. State 10b. County	10c. City, T	own or Locatio	n				10	Od, Inside City Limits
and f show	ō	Maryland Anne Art	ındel (Glen Bu	rnie				1	Yes 2 X No
the Mary 3a or 28a- otified at	Director	10e. Street and Number 263 Margate Dri	ve		10f, Zip Code 210)60		10g. Citizen of W		?
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 X Never Married 2 Married 1 3 Widowed 4 Divorced if Y	2. Was Decedent Ever in U.S. Armed Forces? Yes 2 X No (es, Give Year Dates:	If Yes	Decedent of Hispa s, specify Cuban, I Yes 2 X No	Mexican, Puerto			te, etc.	n Indian, Black,
hours.	edt	15. Decedent's Education (Specify only h	nighest grade completed)	t grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during						ustry
0036 within 72 } ene er than "1	Completed	Elementary/Secondary (0-12) 12th	12th Registered Nurse						ng Hom	ne
215-(be filed a natal Hygi rked oth	Be Co	17. Father's Name (First, Middle, Last) Lester Davidson Christopher, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Joan E. Bush								
D 27 should and Me	۲	19a Informant's Name/Relationship (Type			Address (Street					
mnd 2 sealth a		Joan Christopher / 20a Method of Disposition			Cedar Dri on (Name of ceme		vern, [Maryland		
imore Pages 1 a ment of He tant: If it or other t		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Removal from State _ Cre	ematory or other view Cre	ematory	4/14	4/2006	Baltin	more,	Maryland
Balt permit Depart Impor		21. Signature of Funeral Service Licensee	>	22. Na	me and Address o	f Facility Go	once Fu	meral Se	ervice	, P.A.
Physician /Medical xaminer		23a. Port I. Enter the disease, or complica failure. List only one cause on each I Immediate Cause (Final disease a. P	tions that caused the death. Dine. robable hypoglyce	o not enter the					eart /	and 21225 Approximate Interval Between Onset and Death
760, rotate be executed physician and the burial - transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last XUNPENDED	e to (or as a consequence of): Probable rosiglit e to (or as a consequence of): e to (or as a consequence of): MENDED item#1, per	tazone in ME,g854,	4/20/06 TT					
8760, tificate be ng physici as the buri	n/Medical	IF FEMALE: 2	item#23a,27,28a-	f,perME,	g855,5/17/0	06 TT		23d. Date of	f delivery	
D.O. Box 687 that the death certificated by the attending professed for use as the detached for use as the second for use as the sec	Physician/	23b. Was decedent pregnant in the past 12 months?	Live birth Pregnant at time of deat	2 Feta	I death 3 er (Specify)	Ectopic pregna	ncy	Month		Year
The de	Phy	Part II. Other significant conditions co	Unknown	ulting in the un	derlying cause giv	en in Part I	23e Did	tobacco use conti	ribute to the	cause of doath?
res that the signed by	l by			J	, , ,					y 4 V Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed						24a. Was	psy ormed?	prior to comp death?	sy findings available pletion of cause of
m: The strict of the partition of the pa		25. Was case referred to medical			26.Place o	f Death (Check o	1 Yes	2 No 1	✓ Yes	2 No
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No	ital: 1 Inpatient 2 E	R/Outpatient				Residence 6	✔ Other: So	cene
n of ing Pl After funera		27 Manner of Death 1 Natural 5 Death	28a Date of Injury (Month, Day, Year)	28b. Time of Inju			28d. Describe	how injury occur	red	
Sior Vitend death ctor:	atic	2 Accident S Pending Investigation	Fnd 4/11/2006	Fnd 12:19	9 AM ^{1 Ye}	s 2 X No		ingested (
Division of No the Hospital or Attending Phenthin 24 hours after death To the Funeral Director: After to completely filled in by the funeral	Certification:	3 X Suicide 6 Could not be determined 29a. Certifier 4 Could not be determined	28e. Place of Injury - At hom (Specify) home				Glen Bu	state) 263 M nie, MD	Argate	Route Number, City Dr.
the Ht hin 24 the Fu	Medical	one) 2 Medical Examiner:Or								ause(s)
To vit	Mec		d manner stated.		29c License r			29d Date sign		
nit		Patu aroni	ia-Bllu	M	O.C.M	.E.		April 12, 2		,
strek		30 Name and address of person who com Patricia Aronica-Pollak MD.	pleted cause of death (Item 2 Assistant Medical Ex		111 Penn Stre	et, Baltimore	e, MD 2120	01		
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Loss	00 4					

DHMH 17 Rev 1/2001 OCME 10/2003

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrament Item #31 Per DVR 2854 4/20/06 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Emma **Olivia** Cook /Medical April 16 2006 1:11A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3301 Fairview Road Woodlawn Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months 1 M 2 Director 217-20-4242 90 March 19 1916 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location id other than "naturel", or items 23a or 28s-f show event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3301 Fairview Road 21207-4509 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Dentistry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file from of Health and Mental Hy fant: If Item 27 is marked oth jury or other traumatic even Be ۵ Clarence Flickinger Florence Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Dale G. Cook (Son) 3301 Fairview Road, Woodlawn, Maryland 21207-4509 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Deurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any Injury or once. Lake View Memorial PK -4/19/06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loring Byers Funeral Directors, Inc CONCLINIOUS 8728 Liberty Road, Randallstown, Maryland 21133 23a. Pan Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Failure Physician ongestive disease or condition resulting in death) Jyrs. /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 Probably should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 27. Manner of Death Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)
Injury at 28d. Describe how injury occurred 2 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel [Pritfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated a medical Examiner: On the basis of examination and/or investigation in the cause of th 29a. Certifier Check only one) icai edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

To To Con

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Regist

Michael Pearlman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D



			1 - For Si	ate of Marylan	-	artment of I			_	giene Rag: No.	12	35
			Decedent's Name (First, Middle, Last)						2. Date of De	ath		e of Death
	Physici /Medic		RAYMOND L. COLE	BETH					Month APRIL	13 2006	Year 1.3	0 P M
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of			4c. County o		
			KLINE HOSPICE HOUSE			MI	. AIR	Y		FRE	DERICK	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da	th V Vear)	9. Birthplace (Sta Country)	te or Foreign
	Director		009-05-8116	^{2 F} 87	Yrs.	INOTICIS Days	Tiours	IVIII.		6, 1918	VERMONI	1
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	100 Cib	y, Town or Lo						Late	
	anyta shor	-			y, rown or Lo							e City Limits es 2 ☐ No
	Be-f	acto	MARYLAND WASHINGTO	DN		HAGERS	STOWN					03 2 110
	with t	Funeral Director	10e. Street and Number			10f. Zip Code				10g. Citizen of Wi	•	
	s 23s	ra	360 ANTIETAM DRIVE				2174				.S.A.	
	itam ner	nu	A	Vas Decedent Ever in U. Armed Forces?	5. 13. 1	Was Decedent of I f Yes, specify Cub	nispanic Ori San, Mexicar	gin? (Spe n, Puerto l	city Yes or No Rican, etc.)	14. Hace Black	- American Indiar White, etc.	
36	rs aff	by F		⊠Yes 2□No 194 Yes, Give Year or Dates: 194		1 ☐ Yes 2 ፬ No	Specify:			Specify:	WHITE	
5-0036	within 72 hours after death with the Maryland ene. then "netural", or Itams 23e or 28e-f show the Medical Examitive must be invitited at	ed	15. Decedent's Educatio			dent's Usual Occur	pation			16b. Kind of Bus		
215	n "ne	plet	(Specify only highest grade cor	npleted)	(Give	kind of work done DO NOT use retire	during mos	t of workir	ng		ooaaasii y	
	with with the right	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	MATN	TENANCE	SUPER	VTSO	R	CO	LLEGE	
ᅙ	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "netural", or Itams 23a or 28e-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				1			Maiden Surname		
<u>a</u>	should be filed and Mental Hygi marked other matic event, I	To B	GEORGE C. COLBETH				HATT	IE M	. LAFLE	UR		
Maryland 21	should I		19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailir	g Address (Street	t and Numbe	er or Rura	l Route Numbe	er, City or Town, S	tate, Zip Code)	
	s 1 and 2 should f Health and Men item 27 is marke other treumatic		PHYLLISJ. COLBETH/SE	OUSE	360 A	NTIETAM	DRIVE	, HAG	GERSTOW	N, MARYL	AND 217	42
altimore,	of He fitem		20a. Method of Disposition		lace of Dispo	sition (Name of natory or other pla	ice)	D	ate	20c. Location - C	ity or Town, State	
Ë	Pages nent of int: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 1 ☑ Donation 5 ☐ Other (Specify)	vai from State	-	FOREST (·)4/17	/2006	OWINGS M	ITLLS.MAF	RYLAND
a	permit. Pages Department of Importent: If i any injury or o		21. Signature of Funeral Service Licensee	H00528		. Name and Addre				ld Nation		
ñ	Por E and		Timohister	Timothy Shir	olev B	AST FUNE	RAL HO	MVI H		oro, Mary		713
г			23a. Part1. Enter the disease, of complication shock, or heart failure. List only one car	as that caused the death		er the mode of dyi	ng, such as				Approxir	nate
1	Physician		Immediate Cause (Final	/ ranks	. 1.	0112002					Onset a	nd Death
	/Medical		disease or condition resulting in death)	Due to or as a consequ	Jence on:	un					- ya	w_
	Examiner										V	
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):							
	cuted	Examiner	cause. Enter Underlying Cause (classes or injury that initiated events								- 4	
Ď	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):							
9/60	icate be executed physician and s the burial-transit	ical	d									
٥	ng ph	Medi	IF FEMALE:									
X Q Q	death certific e attending pl id for use as t	an/I	23b. Was decedent pregnant 23c. If	yes, outcome of pregnar		Ectopic pregnanc	v			23d. Date	,	
	0 0	SICI	1 162 Z [NO	Pregnant at time of de		Other (specify) _	<u> </u>			Monti	n Day	Year
r Ö	law requires that the de as been signed by the a 2 should be detached f	Physician/Me	9 Unknown									
Ś	es the	þ	Part II. Other significant conditions contribu	ting to death but not resu	ilting in the ur	iderlying cause giv	ven in Part I.			obacco use contrib		
5	w require	ted							1 🗆 🗅	/es 2 □ No 3	Probably 4	Unknown
Hecords	has by	ple							24a. Was autop		ere autopsy findin or to completion o	gs available if cause of
_	The t	Completed								rmed? de	ath?]Yes 2∐ No	
Vital	ysician: The	Be (25. Was case referred to medical examiner?				26. Place	of Death	(Check only o	ne)	1.50	
0	Physic this c	ပ္	1 ☐ Yes 2 ☐ No Hospi	tal: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	d doa Ott	ner: 4 □ Nu	rsing Hon	ne 5 🗆 Resid	dence 6 Dether	(Specify)	250
_	ding Ph h. After th funeral	on:	27. Manner of Death ↓ Natural 5 ☐ Pending	la. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo	rk?		8d. Describe h	now injury occurred	10	-
<u> </u>	tend death tor: / the fi	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□I					
DIVISION	ii or Attending Physician: after death. Director: After this certifica in by the funeral director.	ertiflcation;	4 Homicide determined 28	Ie. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		2	18f. Location (S City or Tox	Street and Number vn, State)	or Rural Route N	umber,
_	pitei urs a erel [O	200 Contilion									
	Hos 24 ho Fund Fund	edical	29a. Certifier 1 Certifying Physicial (Check only one) 1 Medical Examinar:	 10 the best of my knowns 20 the basis of examinate 31 manner stated 	wledge, death ion and/or inv	occurred at the till estigation, in my o	me, date and opinion, deat	d place, a th occurre	nd due to the od at the time,	cause(s) and manr date and place, an	er as stated. d due to the caus	9(S)
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier	and mainter stated.	· · · · · ·	29c. Licens	se number			29d. Date signed (Month, Day, Year)
	F3F8		In last			\wedge	_	<i>u</i> 1				
į		}	30. Name and address of person who comple	ted cause of death (Item	23a) /T-ma	Print)	221			Cpul and	4 Jul	6
0			A HALLANIA	LA A LA >	E +	inda 1	711	1	1. 1	and	1. (2/1)	
Ė	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signat		200	WIT	11	gue	000	rijuh	
		ar	APR 2 0 2006	FOR SILVER A	P F	Section 1						

				partment of Health a principle of Death		iene 19. No. 12436
	Physici /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Rita Z. Davis		2. Date of Death	Day Year 3. Time of Death 9:23 PM
	Examir Funeral	ner	4a. Fecility Name (If not institution, give street and number) Baltimore Washington Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		ie	4c. County of Dealh Anne Arundel Year) 9. Birthplace (State or Foreign Country)
	Director		216-18-9996			1924 Maryland
	he Maryla 28a-f eho	ector	Maryland Anne Arundel Glen Bu	rnie		10d. Inside City Limits 1 ☐ Yes 🏖 🛣 No
	ath with 1 23a or 3	ral Dir	155 Olan Drive	10f. Zip Code 21061		Og. Citizen of What Country? United States
036	ours after de iral', or Iteme Examinar r	d by Fune	11. Marital Status 1 □ Never Married 2 □ Marned 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Oriell Yes, specify Cuban, Mexican 1 □ Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. White Specify:
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importents if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow may injury or other traumatic event, the Medical Examinar must be notified at ance.	Completed by Funeral Director	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most DO NOT use retired) maker	t of working	6b. Kind of Business/Industry Own Home
Maryland	could be file I Menta! Hy varked othe vatic event,	To Be (17. Father's Name (First, Middle, Last) John Zakrzewski	Mar	or's Name <i>(First, Middl</i> e, <i>N</i> yAnne Majrz	ewski
	is 1 and 2 shot of Health and Item 27 is in other traum		Charles T. Davis, JR. / Son 15		Glen Burnie,	
Baltimore,	Pages 1 lent of Ha nt: If Iter ry or oth		142 Burial 2 Cremation 3 Deemoval from State	osition (Name of ematory or other place) ill Cemetery	April 18,	Oc. Location - City or Town, State Brooklyn Park. MD
Balti	permit. Depertra Importe eny inju		21. Signature of Funeral Servicer Licensee	22. Name and Address of Facility	Funeral Hom	о Р Д
	Attending Physicien: The law requires that the death certificate be executed to death. Codath. Codath. Death this certificate has been signed by the attending physicien and the properties of the properties o	edical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as al Bleod Heart Failu	S.E. CIEN Bucardiac or respiratory arre	rnie, MD 21061 Approximate Interval Between Onset and Death
.O. Box	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that in signed k uld be det	þ	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
al Records,	To the Hospitel or Attending Physicien: The law re within 24 hours after deals. To the Funce to the Fueret Director, After this certificete has bee completely filled in by the funeral director, page 2 sho	Completed	Démentia Seizure dusorder		24a. Was an autopsy perform	prior to completion of cause of death?
ž Vit	hysicier this certi	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ▼ No Hospital: 1 ▼ Inpatient 2 □ ER/Outpatie	ent 3 DOA Other: 4 Nu	of Death (Check only one rsing Home 5 Resider	
Division of Vital	anding P lath. or: After t	ertification;	27. Manner of Death 1	of 28c. Injury at Work? M 1 Yes 2 N	28d. Describe how	v injury occurred
Divis	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		City or Town,	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Certifying Physician: To the best of my knowledge, dea Certifier American Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and ovestigation, in my opinion, deat	d place, and due to the car th occurred at the time, da	use(s) and manner as stated. e and place, and due to the cause(s)
)	To t To t	×	29b. Signature and title of certifler	29c. License number	010 /	d. Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type		on Burnie	1) 71/1
,	Sta Registr		31. Date filed (Month, Day, Year) 22. Registrar's Signature APR 2 0 2006	W OC	en smile	, MD XIVAL

Davis, Rita

			1 - For State Registrar	State of M	Marylan		artmen rtificate				-	giene Reg. No.	000)	12	437
	Dhycini	-	1. Decedent's Name (First, Middle, L								2. Date of De. Month	ath Day	Ye	ar	3. Time	of Death
	Physici /Medio		Rober	t Del	auder						April	19	200		5:0	O A. M
I	Examir	er	4a. Facility Name (If not institution, g 2816 Watervie		or)		4b. City,		Location o			4c. County of Death				
	Funeral Director		212 44 3103	Sex 7.7 1 1 M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da May 28,	th y, Year) 194	9. 15 W	Birthpl Count est	ace (Stat ry) Vir	e or Foreign ginia
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10	d. Inside	City Limits
	Mary	ō	Maryland N/A		E	Baltimo	re						1 ፻ Yes 2[
	r 28e	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What	Count	ry?	
	h will	ai D	2816 Watervie	w Avenue			21230				J	J.S.				
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "natural; or Iteme 23e or 28e-f show any injury or other traumatic event, I'm Medical Exacities court for couling at ODGE.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s? ∐No	i	Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:			1	14. Race - American Indian, Black, White, etc. Specify: White					
Ŏ	2 ho	ted	15. Decedent's			16a. Deced	lent's Usua	d Occupa	tion			16b. Kii	nd of Busine	ss/ind	ustry	
21	e. Bn "r	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4o	r 5+)		kind of wor DO NOT us					-			0	
7	ygien ygien t,	Con	9th			Heav	y Equ	ipme			i		[ermin	al	Corp	•
Maryland 21215-0036	wild be fil Mental H arked oth	To Be C	17. Father's Name (First, Middle, Las Boyd	Delauder							e (First, Middle, ie Cunn		_{laiden Sumame)} ngham			
Jar	2 short and and lam.		19a. Informant's Name/Relationship				_				al Route Numbe					
e î	l and lealth m 27 her t		Estella Delaude	r / wite	00h F	2816					Baltin					230
altimore,	M ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3			Place of Dispo semetery, cren					Date		cation - City			
	it. Partmer rtent njury		4 Donation 5 Other (Spec	-	Bay	yview (,				imore		-	
Ba	Depariment Department Impo		21. Signatore of Funeral Service Lic	namua	unli						once Fun y Balt					
	Physician Medical Examiner Italy physician and	resulting in death) Due to (or as a sensequence of): Due to (or as a sensequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Interval B			
O. Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Fetal at time of de	Ideath 3□	Ectopic pre					2	3d. Date of Month		y Day	Year
<u>. </u>	requires that the reen signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death	but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco us	e contribute	to the	cause o	f death?
Vital Records,	n sign										12/1	es 2[]No 3□	Proba	bly 4 [Unknown
၀ွ	> 20 K	Completed									24a. Was	an	24b. Were	autop	sy finding	ıs avaılable
¥	The lay	E									autop	rmed?	prior death	to com	pletion oi !□ No	cause of
Ia		0	25. Was case referred to medical					J1, =	26. Place	of Death	1 ☐ Yes	2 No	1 🗆 Y	95 2	I NO	
	\$ 20 B	To B	examiner? 1 □ Yes 2 X No	Hospital: 1 Inpat	tient 2 🗆	ER/Outpatien	3 □ DO	A Othe	r: 4□ Nu	rsing Ho	me 5 Resid	lence 6	□Other (S	pecify)		
0	ng Ph Iter th		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time of	28	Bc. Injury Work	at ?		28d. Describe h	ow injury	occurred			
<u> </u>	r Attending P ler death. ractor: After by the funera	atic	2 ☐ Accident investigati	on		,,,,,	М		es 2 🗆	No						
Division of	F 8 E E	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 28e. Place of I	njury - At ho etc. <i>(Specif</i>)	ome, farm, stre	eet, factory	, office			28f. Location (S City or Tow	Street and m, State)	Number or	Rural	Route Nu	m <i>ber</i> ,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai	29a. Certifier 1 Lartifying F (Check only one) 2 Medical Exa	thysician: To the bes miner: On the basis and manners	or examinal	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d ⊌lace. h occurr	and due to the d ed at the time, d	ause(s)	and manner place, and o	as sta lue to t	ted he cause	(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier	111/	h	/	29c.	. License	number		- 2	29d. Date	signed (Mo	onth, D	ay, Year)	
	0		Sans	Alone	YN	w	1	2 8	45	32		A	111	19,	20	00
			30. Name and address of person who		death (Item	23a) (Type, I	Print)	. *	1750000		t., Bal	,				
	Q v			BUNDIA	3	2001 3	out 4	Ha	4010,	- 5	t. Bal	H, m	or, o	UL	>	1225
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0 2		trar's Signa	ture	18 B				•					

			1 - For State Registrar	State of	f Marylar	nd / Depa	artmen <i>tificate</i>	t of H	lealth a Death	ınd M	lental H	ygiene Reg. No.	06	12438
			1. Decedent's Name (First, Middle, Las	(t)							2. Date of	Death		3. Time of Death
	Physici /Medi		John Fillmore Doc	kery, J	r.						Month 4-	16-200	Year 6	10:30PM
#	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	f Death			ounty of Death	
			202 Baylor Road				G1en	Bur	nie			Anı	ne Arur	nde1
	Funeral		Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2	24 Hrs. Min.	8. Date of I	Birth		place (State or Foreign ntry)
	Director		213-22-1012	⊠ M 2□F	79	Yrs.	WORKIS	Days	Hours	IVIIII,	1-1-1	Day, Year) 927	MD	rnry)
	pu .		Usual Residence of Decedent 10a. State 10b. County		100 0									
	aryla eho	-	Toa. State		100.01	ty, Town or Lo	cation							10d. Inside City Limits
	Ne M	ct	MD Anne Ar	unde1		Glen	Burn							1 ☐ Yes 2 🖾 No
	with t	吉	10e. Street and Number				10f. Zip	Code				10g. Citizer	n of What Cou	ntry?
	ath v	G	202 Baylor Road					061				U.S.A	•	
	er de	Funeral Director	11. Marital Status	12. Was Dece Armed For	rces?	l.S. 13. V	Vas Deced Yes, spec	ent of Hi ify Cuba	ispanic Orig n, Mexican	in? (Spe Puerto	ecify Yes or I Rican, etc.)	No- 14.	Race - Ameri Black, White,	
36	s aft	by F	1 ☐ Never Married 25€ Married 3 ☐ Widowed 4 ☐ Divorced	1 (XYes If Yes, Giv Year or Da	в		☐ Yes 2	2X No	Specify:			Sp	ecify:	white
Ş	tural	ba	15. Decedent's Ed		1185:	16a Dagas	lant's Lieus	1.000	ation.			4.01-16:-1	- (D	
Maryland 21215-0036	in 72	Completed	(Specify only highest grad	de completed)		16a. Deced	kind of wor OO NOT us	k done d	turina most	of worki	ng	160. Kind	of Business/Ir	idustry
7	with ene. ther	E	Elementary/Secondary (0-12)	College (1	-4or 5+)		al Wo					11 0	S Post	Office
0	Hyg Hyg other		17. Father's Name (First, Middle, Last)			1051	al WU	IKEI		's Name	(First, Mida	le, Maiden Su		OTTICE
au	d be ental ked c	To Be	John F. Dockery,	Sr.							a Pin		,	
7	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Madical Examinar must be notified at	-	19a. Informant's Name/Relationship (7			19b. Mailin	n Address	(Street a				ber, City or To	num Stata Zir	Codel
Š	Ith a	n i	Mrs. Liliana Docke	•	ifa							nie, MI		
<u>ē</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic e ance.	Y (i	20a. Method of Disposition	-1 y / w.	20b. F	Place of Dispos	sition (Nam	e of	1		ate	-	ion - City or To	
Baltimore,	ages ant of t: if i		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Qonation 5 ☐ Other (Specify	Removal from S	State	emetery, cren			·	20	2006			
	ortme ortme ortan Injur	1	21. Signature of Funeral Service Libert		GTe	n Have						Funer	Burnie	
Ba	Dep imp		Day Ja III	XX /	MX121							rnie, M		
			23a. Part1. Enter the disease, or comp	lications that ca	used the deat	~ _							ID 2100	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on ea	ach line.		~				,			Interval Between Onset and Death
>	Physician /Medical		disease or condition resulting in death)	a		tiple		160	whil!	us	W	crs		
	Examiner			Due to (or as a conseq	uence or):	16							
		e.	Sequentially list conditions, if any, leading to immediate	b. — Due to (c	or as a conseq	uence of):	7)							
	uted d ansit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·		•								
<u>,</u>	exect n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								
8760,	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	(d										
9	ificati g phy as the	edi		u										
Box	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo								23d	. Date of delive	arv
ň	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	nth 2∏Feta antattime of d		Ectopic pre Other (spe						Month	Day Year
Ö	by the	hys	9 Unknown	9□ Unkno	wn									
J	res thet the de signed by the s be detached f	by P	Part II. Other significant conditions co	ntributing to de	ath but not res				n in Part I.		23e. Dio	tobacco use	contribute to the	ne cause of death?
Records ,	quire in sig utd b	b b	H/0 Du	lmor	10139	Su	boh	المراد			1	Yes 2□N	o 3 🗆 Prob	ably 4 Unknown
၀	w requ	Completed	()		\cup						24a. Wa	s an 2	4h Were auto	psy findings available
	he law e has age 2 :	Ĭ,									aut	opsy formed?	prior to condeath?	mpletion of cause of
Vital		ပို	25. Was case referred to medical				-			(D	1 ☐ Yes		1 🗆 Yes	2 No
>	ysiclen: is certific director,	80	examiner?	Hospital:	patient 2	CD/0	•□ po	Othe			Check only			
ō	r this	\vdash	27. Manner of Death	28a. Date o		28b. Time of		c. Injury Work	4 🗀 1907:			how injury o		Y)
0	ding I th. : After s funer	훁	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	i, Day Year)	Injury	м		? ′es 2 ∐ N			,,		
Division of	Atter dea octor by the	<u></u>	3 ☐ Suicide 6 ☐ Could not be	28e. Place	of Injury - At he	ome, farm, stre	et, factory,	office		2	8f. Location	(Street and N	umber or Rum	I Route Number.
5	a afte	Certification:	4 Homicide	buildin	g, etc. (Specif	y)					City or To	own, State)		,
	To the Hospital or Attending Physicien: whith 24 hours after death as a feet death out the Funerel Director: After this certified completely filled in by the funeral director;		29a. Certifier 1 Certifying Phy	sician: To the I	best of my kno	wledge, death	occurred a	t the time	e, date and	place, a	nd due to the	e cause(s) and	i manner as si	tated.
	n 24 n 24 n Fu	edical	one) 2 Medicai Exam	iner: On the ba and mann	sis of examina	tion and/or inv	estigation, i	in my op	inion, death	occurre	d at the time	, date and pla	ce, and due to	the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1/1	_		29c.		number		f	29d. Date si	gned (Month,	Day, Year)
	0			2				DO	063	668	1		9)10	1/06
1	1	1	30. Name and address of person who co		of death (Item	23a) (Type, F	Print)						- 1/	(
U	U			115 R	008100	Rd	812	n i	burn	16	nd	91060		SC
	Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	9							
	Registra	ar	APR 2 n 2008	ARM	Dal Sa	and the same								

			1_ For	State of Marylan	nd / Departm		and Mental Hy	_	AC (01.0)
			Registrar 1. Decedent's Name (First, Middle, Last)		Certific	cate of Death	2. Date of D	Reg. No.	3. Time of Death
	Physici /Medi		THOMAS E	FREBUR			APRIL	13	2006 12:587
	Examir	ner	4a. Fecility Name (If not institution, give s BALTIMORE WASHINGTO	NMEDICAL CEN	TER (City, Town, or Location LEN BURI Inder 1 Year If Under	NE	ANI	
Ш	Funeral Director		5. Social Security Number 6. Sex 152 Usual Residence of Decedent	7. Age (In yrs.		iths Days Hours	Min. (Month, D	/1946	Birthplace (State or Forei Country) MD
ras	Maryland f show	or	10a. State 10b. County MD Anne Ar		ty, Town or Localion	1			10d. Inside City Limi 1 ☐ Yes 2 🗹 N
homa	ith the	Funeral Director	10e. Street and Number	under 1		f. Zip Code		10g. Citizen o	What Country?
5	s 23a	erail	187 Inlet Drive	12. Was Decedent Ever in U	12 Was 5	21122	inin 2 (Canada, Van au N	U.S.	A . ace - American Indian.
	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland to the atth and Mental Hygiene. If Health and Mental Hygiene. the marked other then "netural", or items 23a or 28e-1 show other traumatic event, the Mydical Examinar must be inclined at	by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		specify Cuban, Mexica	rigin? (Specify Yes or N n, Puerto Rican, etc.)	Spec	lack, White, etc.
TREBURGER	Maryland 21215-0036 td 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic svent, the Mydical Exam	eted	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Decedent's	Usual Occupation of work done during mos OT use retired)	st of working		Business/Industry
0	within then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Firef:				more City
The state of the s	laryland 2121 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, Liennaumati	Be Co	17. Father's Name (First, Middle, Last)		riler		er's Name (First, Middle		Department ame)
B	ylano buid be Mentai Arked o	To B	Thomas E. Frebu	ırger, Sr.		Do	rothy Gre	en	
W	Aar)	10	19a. Informant's Name/Relationship (Type	Uan			er or Rural Route Numb		
	Baltimore, Mispermit. Pages 1 and 2 Depertment of Health in Importment: If its m 27 is any injury or other transpace.		Kelly Freburger 20a. Method of Disposition		10331 Place of Disposition		Road, Oce		y, MD 21842 n - City or Town, State
(1-	ages ant of ht: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crematory	or other place)			Burnie, MD
	ialtimore, rmit. Pages 1 a spertment of Hes portant: If Itsm y injury or othe		21. Signature of Funeral Service License			e and Address of Facil			neral Home, I
	Depermination of the service of the		Jaly_	policies and the second	169	Riviera			, MD 21122
	Physician		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the deat the cause on each line.	~		s cardiac or respiratory :	ırrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		/	ine,		
	Lammer	J.	Sequentially list conditions, b	Due to lor as a consell	- mue	motheray	<		
,	uted	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
	60, Cbe executed ician and burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):				
	S × 6	licai		l.					
	Box 68' eath certificat attending phy	/Med	IF FEMALE:	3c. If yes, outcome of pregna	ancv			224 [Date of delivery
	Division of Vital Records, P.O. Box 68 ior Attending Physician: The law requires that the death certifica effer death. Director: After this certificate hes been signed by the attending ph in by the funeral director, page 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 Ector	r (specify)			Month Day Year
	ds, P	by Pt	Part II. Other significant conditions con	tributing to death but not res		ing cause given in Part			intribute to the cause of death?
	COLD w require been si should I	Completed	grow (m	a and			24a. Wa		b. Were autopsy findings availab
	ReC	ошо					auto perf	opsy ormed?	prior to completion of cause of death?
	Vital F ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?			26. Plac	1 ☐ Yes e of Death (Check only	one)	1 Yes 2 No
	Of V Physic this ce	မ	1 ☐ Yes 2 ☐ No H		ER/Outpatient 3		ursing Home 5 Res	idence 6 🗆 O	ther (Specify)
	on of Vital Re ling Physicism: The I After this certificate he funeral director, page	ion:	27. Manner of Death 1 Shatural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐		how injury occu	nred
		Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fa		28f. Location	(Street and Num own, State)	nber or Rural Route Number,
	ths Hospital or hin 24 hours effe ths Funers! Dir npletely filled in	Medical C	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occu ation and/or investiga	rred at the time, date at ation, in my opinion, dea	nd place, and due to the ath occurred at the time	cause(s) and n , date and place	nanner as stated. and due to the cause(s)
	To th within To th	Me	29b. Signature and title of contifier			29c. License number			ned (Month, Day, Year)
)		* WRairs	an MI)		DODIY	171	April	13 2006
	10		30. Name and address of person who co	mpleted cause of death (Item	m 23a) (Type, Print)		> //	D ,	13 2006 e MD 2106
	Sta	ite	31. Date filed (Month, Day, Year)	32 Aegistrar's Signa	ature	Juite ?	05 de	n Dorni	e MD 2106
	Regist		31. Date filed (Month, Day, Year) APR 2 0 200	16 Paras A	T. GOSLE	1			

Amend Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** April Myrtle S. Hedgeman 2006 10:07A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aahtulcare Assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□M 2😾 F 97 Director 304-26-2056 Mar.26,1909 Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentat Hygiene. or 28a-f ehow 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Howard Columbia Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 8518 Wind Dance Way 21045 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Taylor Salughter Tommie E. Tandy 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Carter Smith (God-Child) 5548 High Tor Hill Columbia, Maryland 21045 f Health item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite eny Injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-18-2006 Meadowridge Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road C 21. Signature of Funeral Service License Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical

Certification: To

Medical

State

Registrar

nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line.	Approximate Interval Between
Due to for as a consequence of):	Weeks
Due to (or as a consequence of):	- 1
Myscerdial Lateration	Years
Due to (or as a consequence of):	
· Coronary Artery Visease	Years
Due to (or as a consequence of):	
d	

physicien and s the burial-transit Division of Vital Records, P.O. Box 68760, attending physic for use as the b cate has been signed by the page 2 should be detached within 24 hours after deat To the Funeral Director: completely filled in by

•	d										
IF FEMALE: 23c. If yes, outcome of pregnancy 1											
Part II. Other significant conditions of											
Hypertensin			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	24b. Were autopsy findings available prior to completion of cause of death? 1 \[Yes 2 \] No							
25. Was case referred to medical		26. Place of Deat	h (Check only one)								
examiner? 1 ☐ Yes 2 ☎ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3[□ DOA Other: 4 □ Nursing Ho	me 5 Residence	6 NOther (Specify)							
27. Manner of Death 1		28d. Describe how inj									
3 Suicide 6 Could not b 4 Homicide determined		actory, office	28f. Location (Street a City or Town, Sta	ind Number or Rural Route Number, te)							
29a. Certifier (Check only one) Certifying Photographics (Check only one)	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place, ation, in my opinion, death occur	and due to the cause(red at the time, date ar	s) and manner as stated. Individual place, and due to the cause(s)							
29b. Signature and title of certifier	29b. Signature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) April 17, 2006										
30. Name and address of person who completed cause of death (Item 23a) (Type Print) Jeromz Hantnen, nD 11085 Little faturent fkmy Columbia, nD 21044											
		v . ,									

DHMH 17 Rev 1/2001

2006

APR 2 0

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			Fiease	State of Maryland	d / Depa		Health and		giene	06	and the same of th	
			Registrar		Cei	uncate of	Dealii	2. Date of D	Reg. No.		3. Time of Death	
	Physici	an	1. Decedent's Name (First, Middle, Las	51)				Month	16. 200	Year	4:30 AM M	
	/Medic	al	Elmer John Hansen 4a. Facility Name (If not institution, give	e street and number)		4b. City. Town.	or Location of Dea			nty of Death		
	Examir	er	Stella Maris Long		er	Timor				-	e County	
	Funeral		5. Social Security Number 6. S			If Under 1 Yea	r If Under 24 Hr				place (State or Foreign intry)	
	Funeral Director			YDM 2□F	54 Yrs.	Months Day	s Hours Mir	Jan. 1	9,1942	Mar	yland	
	P .		Usual Residence of Decedent	100 Cia	r. Town or Lo	- etion					10d. Inside City Limits	
	arylar how	_	Maryland Dorc	hester		Secretar	v				1 ☐ Yes 2XXNo	
	he M	ecto	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cou	intry?	
	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow he Medical Examinar must be mailfied at	Funeral Director	120 Poplar Street			Tor. Zip Code	21664		, and a second		USA	
	leath	era	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent o	f Hispanic Origin? Joan, Mexican, Pue	Specify Yes or N	lo- 14. R	ace - Amer		
**	if the real	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give	1	Yes, specify Cu □ Yes 21024N		rto Hican, etc.)		lack, White		
22	e since	by	3 ☐ Widowed 4X ☑ Divorced	Year or Dates:					Spec	,,,	hite	
7	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced (Give	lent's Usual Occ kind of work dor	upation ne during most of w red)	orking	16b. Kind of	Business/li	ndustry	
5	o thin	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		f Employ			Food	& Bev	erage	
7	Hygie theri		unknown 17. Father's Name (First, Middle, Last)	DC1.	Limpio		ame (First, Middi			01080	
2	d be entai	To Be	Waldo L. Hansen,				Paulin	e Taylor				
M Manyland 2121E_003E	shoul nd M	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stre	et and Number or	Rural Route Num	ber, City or Tov	vn, State, Z	ip Code)	
	nd 2 alth a 27 is		Waldo L. Hansen,				ıt Avenue		more, M			
5 A	of He of He rother		20a. Method of Disposition	Permoval from State	lace of Dispo emetery, cren	sition (Name of natory or other p	olace)	Date	20c. Locatio	-		
T.	Peg ment ent: i		Beckleysville Cemetery 4/20/2006 Beckleysville, M									
5:15 A	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depermit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hydene. Importent: if item 27 is marked other then "naturel", or iteme 23a or 28a-1 show important: if item 27 is marked other than "naturel", or iteme 23a or 28a-1 show appear.		21. Signatus Funeral Serve Lice	bouter	Bi 3	Name and Add urgee-He 631 Fa1.	dress of Facility enss-Seit Ls Road	z Funera Baltimo	1 Home, ore, Mar	Inc.	21211	
			23a Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	h. Do not ent	er the mode of o	lying, such as card	ac or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Metast	1	145	ticular	Carc	mond		Onset and Death	
	/Medical	ļ.	resulting in death)	Due to (or as a consequence	uence of):							
	Examiner	_	Sequentially list conditions,	bbue to (or as a consequ	ugana of):							
	be d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uerice or,							
10	te be executed ysicien and le burial-transit	xar	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
900	Sicier sicier	caiE		d.								
2	ifficate g phy as the	edi										
91	attendin for use	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy I death 3	Ectopic pregna	ncy			Date of deli	very Day Year	
17.	deat he att	sicie	in the past 12 months?	4☐Pregnant at time of d		Other (specify)				MORE	Day Tour	
APRIL	that the death certificate of by the attending phys detached for use as the	by Physician/Medi	9 Unknown Part II. Other significant conditions	contributing to death but not res	ulting in the u	ndarlving cause	given in Part I	23e. Die	d tobacco use c	ontribute to	the cause of death?	
P.	w requires that s been signed b should be det		Partitional significant conditions	continuous gradus dans dans dans dans dans dans dans dan		ngan, mg casas	3 , . .		Yes 22No		obabiy 4 Unknown	
	requ been been shoulk	etec						24a. W	as an 24	b. Were au	topsy findings available	
	VILCAI NECOLUS, sician: The law requires t certificate has been signe irector, pege 2 should be o	Completed						- au	topsy rformed?	prior to death?	completion of cause of	
NE	n: Tr ficete or, pe	ဝိ	25. Was case referred to medical				26 Place of F	1 L Yes Death (Check onl	2⊠No	1 LI Yes	2⊠ No	
>-	OI VICAL Physician: r this certifice	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Othor	Home 5□Re		Other (Spec	cify)	
HA	ding Phy After this funeral d		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. li	njury at Work?	28d. Describ	e how injury oc	curred		
(A)	Attending death.	ato	1 Natural 5 Pending 2 Accident Investigation	on	,,		□Yes 2□No					
LME	or Attending after death. Director: After lin by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st	reet, factory, offi	ce	28f. Location City or	n (Street and Nu Town, State)	imber or Ru	ıral Route Number,	
127	Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Funeral Director: After this certificate has been signed by the attending physicien and tell filled in by the funeral director, page 2 should be detached for use as the burial-transit	O	>	<u> </u>			- 4:			l m accord	etatod	
•	he Hospital or n 24 hours aft he Funeral Di pletely filled in	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	thysician: To the best of my kno iminer: On the basis of examina and manner stated.	owiedge, deat ation and/or in	л occurred at the ivestigation, in п	e time, date and planty opinion, death of	coe, and due to the courred at the time	e, date and pla	ce, and due	to the cause(s)	
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29c. Lic	ense number		29d Date sig	ned (Monti	h, Dey, Year)	
	H 3 H 5		- Amestra	e Why H		1	527	40	HPr	11 1	1m 5006	
	10		30. Name and address of person who	completed cause of death (Iter	т 23а) (Туре,	Print)			, <u>, , , , , , , , , , , , , , , , , , </u>		27022	
	1		ERNESTINE WRI			LANEY VA	LLEY ROA.	D, TI	MONIUM,	MD ———	21093	
	Si Regis	tate trar	31. Date filed (Month, Day, Year) APR 2. 0	32. Registrar's Signa	ature	Cooks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,26827 Per Ana Bd Castificate/of Geath Reg. No. 2. Date of Death 3. Time of Death **Physician** Year Yla zun Minor Jones 2006 0815 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUN JEWYRE Houpiter Dy Sinoze 4 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year June 17, 19 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊊M 2□F unk Yrs. Director 91 unk Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28s-1 show eny injury or other traumatic event, the Medical Examinar must be restiting once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊈ Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 S. Pulaski Street Completed by Funeral 21223 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Un
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 図Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S · Wade, State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** ATWEROSCIELOFIC /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attanding physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death ed by the a detached f 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? res 2 X No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBILD 2000 WEST Street Baldinore Mary and Baltimore Arl ENC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

APR 2 0 2006

49

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Leonard Vincent Jarkowski, Sr. 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Great Everable Baltimore Washington Medical Cen. Netruder If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 7, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F 219 01 0881 86 Director Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "natural", or items 23e or 28a-1 show or other traumatic event, the Madical Examinant manual be notified at Maryland Baltimore 1 ☐ Yes 2 🛣 No Director Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 106 West 7th Avenue U.S. Be Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Interportant: if item 27 is marked other then "natural", or iten any injury or other traumatic event, I'm Madical Examinations. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland Elementary/Secondary (0-12) 9th College (1-4or 5+) Self employed Janitorial supplies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Magdalene Trezeciak Vincent Jarkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Jarkowski, Jr./son 192 Falcon Drive Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 4/21/2006 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Kitchie Highway Baltimore, Maryland 21225 manuram 23a. Part. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vent Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 ☐ Other (specify) 4☐ Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peeu : 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number aui) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eviltospe 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month KOZACZENKO SOPHIE 0600 M APRIL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Care Center Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 🔀 F Director Yrs. 050-32-4108 25,1922 Poland Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show other treumatic event, the Madical Examiner must be notified at Director Dundalk Maryland Baltimore 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 7216 Bayfront Road 21219 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Iter any injury or other treumatic event, the Medical Examinat one. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify 3 ☑ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Homemaker Own Home IIkn. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7216 Bayfront Road Mrs. Monica Bossard (Daughter) Edgemere, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Stanislaus Cemetery 4/21/2006 Baltimore, MD Fureral Service Lic 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Advanced end-stage Alzheimer's disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospitel or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by type 2 DM OSTLOPOPOSIS, CHRONIC OLNUMIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 2 No 1 Yes of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 🗙 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 Pending Injury after death.

I Diractor: Af
d in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 1300 CRENISIL, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 2 0 2006 Registrar

			1 - For State of Maryland	d / Department of Health and N Certificate of Death		rgiene	12445
	Physici	an	Decedent's Name (First, Middle, Last) Mary Linda Kochendorfer		2. Date of De	Day Year	3. Time of Death
9	/Medic Examin Funeral Director	ner	4a. Facility Name (If not institution, give street and number)	Ab. City, Town, or Location of Death (NTE C (LEN BURIE ast birthday) Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da	rth 9 Birthp	UDE L place (State or Foreign
	Aaryland f ehow	or	10a. State 10b. County 10c. City	r, Town or Location		1	0d. Inside City Limits 1 ☐ Yes 2 XNo
	with the N 3a or 28a-	i Director	10e. Street and Number 6394 Beechfield Ave.	10f. Zip Code 21075		10g. Citizen of What Cour	
√ L. 036	be illed within 72 hours after death with the Maryland ital Hygiene. of other then "naturel", or Itams 23a or 28a-1 ehow event, the Madical Experities must be notilled at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.s Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give A Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (Sprilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Americ Black, White, Specify: White	etc.
MARY 1215-0036	ithin 72 ho ie. ien "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of works life. DO NOT use retired)	ing	16b. Kind of Business/Ind	,
- 0	a la b ≱	Be	12 17. Father's Name (First, Middle, Last)			Browns Motor T	burs
71-30	2 should be and Mental I marked o	7	Raymond Covey 19a. Informant's Name/Relationship (Type, Print)	Jean McGrov 19b. Mailing Address (Street and Number or Rure	al Route Numbe		Code)
	ges 1 and 2 should it of Health and Men if Item 27 le marke or other traumatic		Clarence J. Kochendorfer: 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	6394 Beechfield Ave., Elkrid ace of Disposition (Name of Imetery, crematory or other place)	bge, MD 2	21.075 20c. Location - City or To	wn, State
KOCHEN Baltimore,	permit. Pages Department of Important: If It any Injury or o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	wridge Memorial Park, INC 04 22. Name and Address of Facility Cary L. Kaulman Funeral F		Elkridge, MD	
8	80553		M01378 23a Part 1. Enter the disease of complications that caused the death shock, or hear failure. List only one cause on each line.	7250 Washington Blvd., E	Ikridoe,	MD 21075	Approximate Interval Between
68760, "	Physician /Medical Examiner bhysicien and bhysicien and stipe pritarial transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence of the c	ation preume: ence of): eartitis ence of):	4		Onset and Death I clay 3 clay 3
. Box	Attanding Physician: The law requires that the death certific reasth. sctor: Atter this certificate hes been signed by the ettending porthe funeral director, page 2 should be detached for use as in	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of delive Month	ry Day Year
ırds, P	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resu	lting in the underlying cause given in Part I.	23e. Did to	obacco use contribute to th	
al Reco	: The law ricate hes be page 2 sh	Completed			24a. Was autop perfo 1 Yes		osy findings available appletion of cause of 2 No
Vita	ysician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ E	26. Place of Death P/Outpatient 3 DOA Other: 4 Nursing Hor		one) dence 6 ⊟Other (Specify	
Division of Vital Records, P.O	tel or Attending Physicien: 1 s after death. el Director: After this certificat ed in by the funeral director, p	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be determined determined.	28b. Time of linjury at Work? M 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	how injury occurred Street and Number or Bura	
Ď	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and the basis of examina	Aledge death occurred at the time, date and place a	City or Tox	cause(s) and manner as at	ated,
•		Medical	29b. Signature and title of certifier Lace Survey N	29c. License number 1) 24 385		29d. Date signed (Month, I	
P	\ D Sta	tę	30. Name and address of person who completed cause of death (Item Baltimore Washington Media 31. Date filed (Month, Day, Year) 32. Registrar's Signatu	cal Center 301 Has	E Wi	Tesmo Drive Gle	a Burnie
DHI	Registr	ar	APR 2 0 2006	Specific			
				ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Willa J. Kitzmiller 7:12 A.M April 18 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 27, 1 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛱 F 69 Yrs Director 219 32 4454 1937 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2X No Glen Burnie Anne Arundel Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Blue Water Court Unit #204 21060 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 🛛 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education during most of working (Give kind of work done di life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10th 27 la marked other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pauline O. Powell Kenneth L. Murphy ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Blue Water Ct. #204 Glen Burnie, Maryland 21060 tem 27 other tra Junior Kitzmiller / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any Injury or ance. Baltimore, Maryland 4/19/2006 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licens Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Oudiopulmanary
Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner obstructive lung disease MOMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physicien and for use as the burial-transit The law requires that the death certificate be executed bummon, a Exam that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ s been signe 2 should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No Hospital or Attanding Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification; To 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onh one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 140 18/06 D420 41 leted cause of death (Item 23a) (Type, Print) 30. Name and add/ess of pe who comi Ritchiu HNY Brooklyn Park, MD 21225 Alcaado Eli 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 2 0 2006

ORIGINAL

			1 - For State Registrar	State of	f Maryland		artment <i>rtificate</i>			and M		ene g. No. 0		1244.7
П	Physic	ian	1. Decedent's Name (First, Middle,	Last)							2. Date of Death Month		Year	3. Time of Death
	/Medi	cal		Erne		Ly1					4	16	2006	8:00 P.M
	Examir	ner	4a. Facility Name (If not institution, g Genesis Multi		*		4b. City, T			of Death		4c. County		
i.A.	Funeral	2000			7. Age (In yrs. last	birthday)	If Under 1	7SON Year	If Under 2	24 Hrs.	8. Date of Birth		1to	lace (State or Foreign
	Director		220-02-0778	. Sex 1 M 2 ☐ F	39	Yrs.	Months	Days	Hours	Min.	(Month, Day, 5 22	^{Уөаг)} 1966	Coun	Md
	pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or L	nation							
	Maryli 1 sho	JO.	,	/A	,		cation						1	0d. Inside City Limits X☐ Yes 2 ☐ No
	r 28a	rect	10e. Street and Number	/ A	Balt	.0	10f. Zip C	ode			10	g. Citizen of	What Cour	
	th with	Funeral Director	525 Winston Ave	nue					1212			U S		, .
	r dea	Iner	11. Marital Status	Armed For	dent Ever in U.S.	13.	Was Decede	nt of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rac	e - Americ	an Indian,
36	s afte	by Fu	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv	2 K) No e		I□Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	110411, 010.7	Specif		ыс. .ack
9	72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 show distal Examiliat must be motified at	edt	15. Decedent's	Year or Da		6a. Decer	lent's Usual	Occupat	tion		1	6b. Kind of B		
215	hin 73. B. Bn "na Medi	plet	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-		(Give lite.	kind of work OO NOT use	done du retired)	iring most	of working	ng ''		's Ca	
2	ed wit	Completed	12th Grade		N/A		Sa1	es l	Manag	er				
Maryland 21215-0036	be fill d oth	Be	17. Father's Name (First, Middle, La David Ly1e	st)							(First, Middle, Ma		10)	
Z	d Mer mark	2	19a. Informant's Name/Relationship	(Type Print)		Ob Mailie	- 4-1-1 //				a Colber			
	nd 2 suith an 27 is r trau		Anna Lyle - Moth								Route Number,		State, Zip	Code)
re,	is 1 and of Head		20a. Method of Disposition			of Dispo	w IIIS L sition (Name natory or other	of			alto MD	ZIZIZ Oc. Location -	City or To	wn, State
<u>E</u>	Page nent c		1 ☐ Burial 2X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		nate	_	matory		- 1	-19-	2006 C	Catons	ille,	, Md
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any rightry or other traumatic event, the Medical Expreter must be notified at once.		21. Signature of Funeral Service Lic	ensee	2	22	. Name and	Address	of Facility	Ma	rch West			
	00 F = 0		/ /www.cc	10,4	MAM			4300) Wa	bash	Avenue	Ba]	to, N	4D 21215
			23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	y one cause on ea	iused the/death. Dich line.	o not ente	er the mode of	of dying,	such as c	ardiac or	respiratory arres	t,		Approximate Interval Between Onset and Death
ă.	Physician /Medical		disease or condition resulting in death)	-a. EN		ACI	Ξ	911	25				Y	nonlin
	Examiner				or as a consequence	e of):	TI	.0.	. =					(
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		or as a consequenc								1	CYA(
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
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m	death	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1∐Live bir 4∏Pregna 9∏Unknov	th 2 Fetal dea int at time of death		Ectopic preg Other (spec					Moi		Day Year
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ds,	The law requires that tte has been signed b page 2 should be deta	þ	Part II. Other significant conditions	contributing to dea	ath but not resulting	in the un	derlying caus	se given	in Part I.					a cause of death?
Records,	w requir been si should I	etec					-				-			bly 41 Unknown
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		0	25. Was case referred to medical			_			oc Diago	of Darah	1□ Yes 2€	No 1	☐ Yes 2	2□ No
Ξ	nyeici nis cer direc	10 B	examiner? 1 Tyes & No	Hospital: 1 🗆 In	patient 2 ER/C	Dutpatient	3□ DOA				Check only one) e 5 ☐ Residence	e 6 □Othe	er (Specify)	
n of	Attending Physician: or death. ector: After this certific by the funeral director.	on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b , Day Year)	. Time of Injury	28c.	Injury a Work?	t	28	3d. Describe how	injury occurr	ed ed	
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DIVISION	Itel or At rs after d el Direct led in by	Certificati	4 Homicide determine	4 28e. Place c	of Injury - At home, g, etc. (Specify)	farm, stre	et, factory, o	fice		28	3f. Location (Stree City or Town, 5	et and Numbe State)	er or Rural	Route Number,
	epite	<u>a</u>	29a. Certifier Certifying P	hysicien: To the b	pest of my knowled	ge, death	occurred at t	he time	date and	place ar	nd due to the caus	se(s) and ma	nor as sta	tad
	To the Hoepitel or within 24 hours after To the Funerel Dire completely filled in b	edic	(Check only 2 Medical Exa	miner: On the bas and manne	sis of examination a	ind/or inv	estigation, in	my opin	ion, death	occurre	at the time, date	and place, a	nd due to t	the cause(s)
	To the comp	Σ	29b. Signature and title of certifier				29c. L	cense r	umber		29d	Date signed	(Month, D	ay, Year)
	9			< ND			DC	005	31	50	AP	RIL 1	790	2006
	10		30. Name and address of Misson who Shaw Name	completed cause	of death (Item 23a) (Type, F								OLUMBIA 21045
78.6	Stat	e	31. Date filed (Month, Day, Year)	32. Rec	gistrar's Signature	٥٥٥	してでし	14 (401	H	1) ,301	TE I	0	21045
	Registra		APR 2 0 20	F.7	un of	Agen								

			Please T	ype or Prin State of Ma						Are Legible	13110
			1 - State Registrar				cate of			Rag. No.	12448
	Physici /Medic		Decedent's Name (First, Middle, Last)	Betty Lo	ou Loc	ckard			2. Date of De.	Day Year	2 1 7 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Examir		4a. Facility Name (If not institution, give s Franklin Square	11 1	1 Cei	nter 46.	//	or Location of Deal	th C	4c. County of De	imore
	Funeral Director		5. Social Security Number 6. Sex 217-56-9290 Usual Residence of Decedent	7. Age	(In yrs. las		Under 1 Year onths Days	If Under 24 Hrs Hours Min		y, Year) (irthplace (State or Foreign Country) aryland
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	with the a or 28a	Director	10e. Street and Number				Of. Zip Code	.1.000		10g. Citizen of What C	•
	ns 23	ега	7801 Peninsula I	Expressway 12. Was Decedent E		13 Was I	Decedent of H	21222	Specify Vos or No.	United S	
336	hours after death with the Maryland turel; or Items 23a or 28a-f ehow at Exeminational be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			es 28 No		Specify Yes or No- to Rican, etc.)	Black, Wh	
2-0	72 hours natural;	ted	15. Decedent's Educ (Specify only highest grade	cation		16a. Decedent's	Usual Occup	pation	etrin e	16b. Kind of Busines	
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	2 should be filed within and Mental Hygiene. Ie marked other then saumatic event, the Mannatic event.	P	19a. Informant's Name/Relationship (Typ			19h Mailing Ad	dross (Stroot			or, City or Town, State,	
Ma	nd 2 salth ar 27 io		Gloria Mae Wetzel							ndalk, Mary	
ie C	s 1 ar	1	20a. Method of Disposition		20b. Plac	e of Disposition etery, cremator	(Name of	00)	Date	20c. Location - City o	r Town, State
Z E	Page nent o		t ☐ Burial 2√3Cremation 3 ☐Re 4 ☐Donation 5 ☐ Other (Specify)	emoval from State	1	top Sei			20/2006	Towson,	Maryland
ochard betty Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If Item 27 is marked other then eny injury or other traumatic event, the ponce.		21. Signature of Huneral Service License	e_ Ma	1000	Λ.				Dundalk, 1	
J.			23a. Part. Enter the lisease, or complic shock, or heart failure. List only one	cations that caused t	he death. (7922	2 Wise	Ave. Du	indalk, N		21222 Approximate
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XO	leath certificate ettending phys I for use as the	M/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy					23d. Date of de	livery
Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certificate creath. scion: Attent this certificate has been signed by the ellending phy. by the funeral director, page 2 should be deteched for use as the	Physician/Medic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown			pic pregnancy ar (specify)	/		Month	Day Year
Э.	ires that the designed by the		Part II. Dther significant conditions cont	ributing to death but	not resultin	g in the underly	ring cause give	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ords	w requires been signs should be	ted by							1□Y	es 2 No 3 P	robably 4 Unknown
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r o	ding f h. After funer	lon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	Year) 281	b. Time of Injury M	28c. Injun Worl		28d. Describe h	ow injury occurred	
/isi	Attend r death ector: /	fica	3 Suicide 6 Could not be	28e. Ptace of Injury	y - At home			Yes 2 □ No	28f. Location (S	treet and Number or R	ural Route Number
Ö	Hospital or, 24 hours after Funeral Dire tely filled in b	Certification:	4 Homeday	building, etc.	(Specify)				City or Town	n, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examine	cian: To the best of er: On the basis of e and manner state	xamination	dge, death occu and/or investiga	irred at the timation, in my op	ne, date and place pinion, death occu	e, and due to the corred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11			29c. License	e number	2	9d. Date signed (Mont	h, Day, Year)
			1/2/	hur	-u	11-	Kee	0000)	04-15	-06
(1	25		30. Name and address of person who com	npleted cause of dea	th (Item 23	a) (Type, Print)	Ca	Λ.	1	1.	1021737
	Stat	6	31. Date filed (Month, Day, Year)	P. Registrar	S Signature	annli	n gu	are Dri	VP DQI	timore, "	1021737
	Registra	ar	31. Date filed (Month, Day, Year) APR 2 0 2006	Cleron	A.	200000	N				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 10d per th 254 4-20-06 vt.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LELAND C. LAMBE 20:56 M 40 17 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNIV. OF MARYLAND MEDICAL SYSTEM BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 247 - 82 - 3077 55 Director SC 02, 28, 1951 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or iteme 23a or 28a-f ehow traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits X⊡Yos 2**X** No SC Horry Myrtle Beach Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 Legion Street 29577 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. X Yes 2 No If Yes, Give 1969-74 Year or Dates: 969-74 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Disabled 12 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Dwight C. Lambe Leona B. Bray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Amy David - Daughter 538 46th Street, Baltimore, MD 21224 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Department of H Important: If Ite any injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 4-20-06 Baltimore, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility B radley - A shton Funeral Home, P.A., 2134 Willow Spring Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) SEPSIS POLYMYCROBIAL 76 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I amy, bearing to immediate cause. Enter Underlying Cause (Disease or injury Examiner Duly to (or as a consequence of). death certificate be executed that initiated events resulting in death) Last ending physicien a Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery etter for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by ACUTE RENAL FAILURE page 2 should 1 🗌 Yes 2 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? RESPIRATORY FAILURE 24a Was an 1 ☐ Yes 2 No certificate 2 No 1 Yes Hospital or Attending Physician: : After this certifical funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death. To the Funeral Director: A 2 Accident 1 Yes 2 No the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examilities: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/17/06 montro, M.D. P17699 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) GREENE ST BALTIMORE, MD SOUTH 21201 31. Date filed (Month, Day, Year) APR 2 0 2006 3. Registrar's Signature Coaste State Registrar

			Pleas Amend 1_ State Amend item#	se Type or Pri item 19 per 1,17,19a,per	nt in E fin 985 larytan D.FH.G	Hack Ind 4-20-0 d / Depa 354,4/21	lelibl 6 vt irtmei 706 T	e Ink.	Ensu	re Al	I Copies Iental Hy	Are	Legible	. 245(0
			Registrar 1. Decedent's Name (First, Middle,					e or L	Jeam		2. Date of De	Reg. No	D .	3. Time of Deatl	
	Physici			Last) Joseph J king Jr		кing, Jr	•				Month April	19		r	м
	/Medic Examin		4a. Facility Name (If not institution,	<u> </u>			4b. City	, Town, or	Location of		APLIL	-	County of De		
	LAGITITI		Stella Maris	Hospice			То	wson				Ва	altimo	re	
	Funeral			6. Sex 7. A	ge (In yrs. I	ast birthday)		r 1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year	9. 8	lirthplace (State or Fore Country)	əi g n
	Director		215-22-0739 Usual Residence of Decedent	TEM ZOF	78	Yrs.					8-9-1	1927	7	MD	
	death with the Maryland me 23a or 28a-f ehow crivest be notified at	Funeral Director	10a. State 10b. County MD Balti	more		onsvi	11e	p Code				100 C	itizen of What	10d. Inside City Lim 1 ☐ Yes 2Д☐	
	a or	2	10e. Street and Number 102 Fairfield	Drive				1228				U S		Country	
	ne 23	era	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13. V	Vas Deci	dent of Hi	spanic Ori	gin? (Sp	ecity Yes or No		14. Race - A	merican Indian,	
0000	ours after or rei', or iter	þ	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 XYes 2 If Yes, Give Year or Dates] No			ecify Cuba 2 <u>∏</u> No	Specify:	n, Puerto	Rican, etc.)		Black, W Specify₩h		
7-017	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and I terme 23e or 28e-f show item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, the Medical Exeminar must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2		r 5+)	16a. Deced (Give life. L	kind of w OO NOT	ork done d use retired	luring mos)		ing		Kind of Busine		C
7	Hygie Hygie other		17. Father's Name (First, Middle, L	ast)		DISL	IIC	L Ha			e (First, Middle			<u>elephone</u>	
Ö	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ita Ms	To Be		king king Sr					Ju1	ia	Flanni	gan	1		
ary	shou and M mar umat	-	19a. Informant's Name/Relationsh			19b. Mailin	g Addres	s (Street a	and Numbe	or Or Rur	al Route Numb			a, Zip Code)	
Σ.	and 2 salth a n 27 is		Joan Lucking Lucking	- wife				fiel	d Dr	ive	Cators Balt	1mc	ro. M	D 21228	
9	of He		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from Stat	e c	lace of Dispo: emetery, cren	natory or	other place			Ďate .			or Town, State	
Dallillo	ment tant:		4 Donation 5 Other (Sp		Wo	odlaw							timor		
0	permit. Pages Department of It Important: If ite any injury or of		21. Signature of Funeral Service L	icensee							adiey- Spring			uneral Ho) m ∈
i		_	23a. Part1. Enter the disease, or o	complications that cause	ed the death								, 21	Approximate Interval Between	
	Physician /Medical Examiner		shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)		G CANO									Onset and Death	
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	is a consequ	uence of):							-		
68/60, Ø	e be executed /sician and e burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	is a conseq	uence of):									
O. Box 68	w requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic Other (oregnancy specify)					23d. Date of Month	delivery Day Year	
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l Hecor	sician: The law rec certificate hes bee rrector, page 2 shor	Completed									24a. Was auto peri 1 Yes	psy ormed?	death		able ol
VITal	Physician: this certificanal director, I	Be	25. Was case referred to medical examiner?	11				Ta.			h (Check only	опе)			
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	g eur	lon	27. Manner of Death 1 Natural 5 Pending investig		Day Year)	28b. Time of Injury	м	28c. Injun Work	vat ⟨? Yes 2 🗍	No	28d. Describe	now inj	ury occurred		
UIVISION	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of I	njury - At ho etc. (Specif	ome, larm, str y)					28f. Location City or To			Rural Route Number,	
	e Hospitu 124 hours e Funera letely fille	edical	29a. Certifier (Check only 2 Medical E	g Physician: To the best Examiner: On the basis and manner	of examina	wledge, death tion and/or in	occurre vestigation	d at the timen, in my of	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	cause(, date ar	s) and manner nd place, and	as stated. due to the cause(s)	
	To the within To the comp	Me.	29b. Signature and title of certifier)			2	9c. License				29d. D	ate signed (M	onth, Day, Year)	
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	10		30. Name and address of person w	-1		n 23a) (Type, NEY VAI		RD.	TTMO	NTIM	, MD 2	1093	,,		
y.	Str	ate	31. Date filed (Month, Day, Year)								حدد ر				
	Regist		APR 2 0	2006	USW S	ature									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** MICHAEL Month UNDELL PRM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 1922 Norman Road Glen Dulling

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. 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Birthplace (Month, Day, Year) | 9. Birthplace (Month, Day, Year) | 9. Birthplace (M 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXXM 2□F Director 94 Vrs 097-10-9624 Usual Residence of Decedent the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Exactings must be notified at 1 ☐ Yes 2√ No Glen Burnie Maryland Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 United States 21060 Ітета 23а 1922 Norman Road deeth y Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1944- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after tent of Heelth and Menta! Hygiene. nent of Heelth and Menta! Hygiene. ant: If item 27 Is marked other than "natural", or Iter 1 Never Married 2 Married 1XXYes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1945 White 1 Yes 200No Specify: þ 3 Vidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Wastewater Foreman Water & Sewage 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Be Maria DeMartino Pietro Mundello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth a Important: If item 27 is any injury or other tree once. 1922 Norman Rd. Glen Burnie, MD 21060 Michael R. Mundella / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State Aprilate24, n Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Ridge Cemetery 2006 Inverness, Florida 21. Signature of Juneral Service Licensee kirkley-Ruddick Kirkley-Ruddick 421 Crain Hwy. S.E. Glen Burnie, Mp 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DOMONTI A disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by peq DRONARY ARTERY DISCASE 200 No 3 Probably 4 Unknown 1 ☐ Yes DECUBITUS ULCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? HEPERTENSION certificate Division of Vital 2/2 No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: To the ...
within 24 hours
To the Funeral Director. 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vereprans HIGHWAY MICHASSULLE, MD MICHAEL + takker 8601 32. Registrar's Signature State Registrar APR 2 0 2006

		1	For State	State	of Marylan		ertment of H		d Ment	tal Hygie	/ 11:		1245	52
			Registrar 1. Decedent's Name (First, Middle,	Last)						ate of Death			3. Time of D	Death
	Physicia	an	BILLIE J.		LIANO)				Month DU	Day S	2006	17-3	33M
>	/Medic Examin	al er	Ia. Facility Name (If not institution,	give street and	I number)		4b. City, Town, or	Location of De	eath	1	4c. Count	y of Death		
	Examin	Ŭ.	TOHIOS HOPKING	> BAY	IEW HEL	NCHC	BALTI	HORE	E					
	Funeral	- 1	5. Social Security Number	6. Sex 1 ☐ M 2 🕱	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 h	Ain. A(A	ate of Birth Month, Day, Y	ear)	9. Birthpl Count	ace (State or	Foreign
	Director	-	212-34-0769	1 L M 2 A	F 68	Yrs.			Au	gust 7	1937	<u>'</u>	Ohi	6
	P 3	_ <u></u>	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation -					10	d. Inside City	y Limits
	sho ed e						HIMOR	C					1 XYes	2 🗆 No
	28a-1	ect	MARY AUD				10f. Zip Code			10g	. Citizen of	What Coun	try?	
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	me 20	Funeral Director	11. Marital Status	12. Was I	Decedent Ever in U.	S 13	Was Decedent of H	ispanic Origin?	(Specify	Yes or No-		ice - America		
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2	natu	ete	15. Decedent (Specify only highes	s Education t grade comple	ted)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of	working	16	ib. Kind of t	Business/Ind		
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Itame 23e or 28e-f show na Medical Examiner must be motified at	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+)	05	7. A	sistr	ant-		-1+y	のナだ	AHI	MOre
	filed Hygi other	ပိ	17. Father's Name (First, Middle, L	ast)		1				st, Middle, Ma	iden Suma	ımə)	*	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar of Heath and Mental Hygiene the firm 27 is marked other than "natural", or items 23s or 28s-f show item 27 is marked other than "natural", or items to notified at other traumatic awant. Its Medical Examinar must be notified at	To Be	SAMUEL T	hurst	ON	WAR	NICK	Ge	0191	A L	_ وو	K	IRK	
ary	shou and M mar umat		19a. Informant's Name/Relationsh	nip (Type, Print)	Daughter	19b. Maili	ng Address (Street	and Number or	r RuraURou	ute Number, C	City or Town	n, State, Zip		
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Ĕ	nit. Pages ertment of l ortant: If it injury or o		4 ☐ Donation 5 ☐ Other (Sp	pecify)	Mos	st Hoc	Y Redeer	yer Ap	ril 22	2,06 B	Alt	MOrc	MAR	HAND
Baltimore	permit. Page Depertment of Important: If any injury or ance.		21. Signatur of uneral Service	igensee		-2	Y Redeel Name and Addre 032Ph N.	ss of Facility	iNO J	F. Fun	CRAC	Ho	ME	
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	/Medical Examiner		,		e to (or as a conseq									
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89	death certificat e attending phy id for use as th	Med	IF FEMALE:											
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	101	s, outcome of pregna ive birth 2 ☐ Feta	death 3	Ectopic pregnanc	У				ate of delive Month		'ear
0	0 0 2	Physician/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at time of d Jiknown	ieatn 5t	Other (specify) _							
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Sor	w requir been si should	ete		,						24a. Was an	246	. Were auto	psy findings a	available
Re	The lav	Completed								autopsy performe 1 Yes 2	ed?	prior to condeath? 1 Yes	npletion of ca	tuse of
ta		0	25. Was case referred to medical					26. Place of		heck only one,		10.103	20110	
<u>=</u>	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 Impatient 2	ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗌 Nursir	ng Home	5 Residen	ce 6 🗆 O	ther (Specif	v)	
0	ding Ph h. After th funeral		27. Manner of Death 1 Matural 5 ☐ Pendin	28a. l	Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inju Wo	ry at rk?	28d.	Describe how	injury occi	urred		
ioi	Attending ir death. sctor: After by the fune	atic	2 ☐ Accident investig	gation			M 1	Yes 2 No						
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	To the Hospital o within 24 hours at To the Funeral D completely filled in	Medical		Examiner: On	the basis of examina manner stated.)
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. Licen	se number		29	d. Date sign	ned (Month,	Day, Year)	
			Misha	We	ade M	(D, Ph)	D RE	5001		(24/1	8/2	2006	
_	6		30. Name and address of person AUTSHA LO AOC	who completed	cause of death (Ite	m 23a) (Type			ORE	, MD .	2122	24		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 2 0		32. registrar's Sign		neck							
						-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>006</u> Month **Physician** 15, Apri1 10:00 A.M Willard Leroy Miller /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□ F 89 Yrs. 215-05-3807 1916 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic avent, the Madical Examinar must be notified at once. 1 Yes XXNo Directo Maryland Baltimore Catonsville 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 21228 29 Tanglewood Road America of Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1942— WXYes 2□No 1945 1945 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes XXNo Specify: Baltimore, Maryland 21215-0036 þ XXWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Liquor Store 12th Store Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sadie V. Martin William Lewis Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Severna Park, Maryland 21146 281 Riverdale Road: Jean Miller (Daughter in law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XXX Burial 2 ☐ Green ation 3 ☐ Removal from State 20c. Location - City or Town, State April 19, 4 Donation Other (Specify) Loudon Park Cemetery 2006 Baltimore, Maryland 21/ Signature of Funding Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 2122 Approximate Interval Between Onset and Death Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 48 CATG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine signed by the ettending physicien and d be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Minknown certificate has been s irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 □ DOA ို this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. the 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) efter Dire 4 Thomicide within 24 hours a To the Funerei L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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Registrar

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31. Date liled (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Clen Burnie MD2

			1 - For State Registrar	tate of Maryland	/ Departmer		•	_	12454
100	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Wesley R. 4a. Facility Name (If not institution, give street		CÍ 4b. City	te of Death	2. Date of Deat Month	Day Year	6 315 PM
Selection of the select	Funeral Director		5. Social Security Number 215–14–0968 Usual Residence of Decedent	nd Mcdical G	t birthday) If Unde	Dalhmore or 1 Year If Under 24 Days Hours	Hrs. 8. Date of Birth Min. Month, Day 5-16-19	9. Bi 023 MA	N/A rthplace (State or Foreign Jountry) RYLAND
	e Maryland ta-f ehow illied at	ctor	10a. State 10b. County MD BALTIM		Town or Location	MIDDLE I	RIVER		10d. fnside City Limits 1 ☐ Yes ※XNo
	ith with th	Funeral Director	10e. Street and Number 3726 SENECA GARDEN	S ROAD	10f. Zij	Code 21220		og. Citizen of What C	*
9800	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f show littel Examiner roual be maillied at	by	1 Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces? I (XYes 2 ☐ No If Yes, Give Year or Dates: WWII	13. Was Dece ff Yes, spe 1 \(\text{Yes}	dent of Hispanic Origin' orify Cuban, Mexican, Pi 2[XNo Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify: W	
21215-0036	J within 72 h jiena. r than "natu	Completed		mpleted) College (1-4or 5+)	life. DO NOT u	ork done during most of ise retired)	working	6b. Kind of Business	,
ind 2	be filed tal Hygi d other	Be	12 17. Father's Name (First, Middle, Last)	2	FABR		CIALIST Name (First, Middle, N		Α.
Maryland	should and Men is marke	^L	19a. Informant's Name/Relationship (Type,			EMMA s (Street and Number of		(VOGEL) City or Town, State,	Zip Code)
	s 1 and 2 f Health Item 27 i		DARLENE M. RASINSKI 20a. Method of Disposition	20b. Place	e of Disposition (Na	ROSE AVENUE		E, MD 2	1237
Baltimore,	Page nent o ant: If ury or		1 Burial 2 Cremation 3 Remo	valifori State	Y HILL CE	METERY 4-	-20-2006	PARKVILLE	, MD
Ba	permit. Departi Importi any nj		21. Signatur of Auneral Service Licensee		1211 C	nd Address of Facility (Chesaco Aver	nue Rosed	Male, Md	AL HOME 21237
	Physician /Medical Examiner	Examiner	23a. Parti-Emer the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c	Due to (or as a consequent	so of): Spine	lyure	1	N. X	Approximate Interval Between Onset and Death NOUVLS
Box 68760,	rtificate be executed ng physician and as the burial-transit	cal	d	Due to (or as a consequen-	ce of):	1	A ROPROVED BY ME	HOM EM	
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Records, P	requires tha		Part II. Other significant conditions contribu	iting to death but not resultin	g in the underlying c	ause given in Part I.		acco use contribute to	o the cause of death?
ital Rec	hysician: The law his certificate has t i director, page 2 s	Be Completed	25. Was case referred to medical			26. Place of C	24a. Was an autopsy perform 1 Yes 24	prior to death?	utopsy findings available completion of cause of
ot <	Physic this ce at direc	၉	axaminer? Yes 2 □ No Hospi	U⊒Inpatient 2 ER/	Outpatient 3 DC	Other: 4 Nursing	Home 5 Residen		cify)
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DIVI	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	4 Citionida		farm, street, factory Home		Balh	more it	10 GAREN
	ne Hosi in 24 ho he Fune pletely f	edical	La mountain examination.	n: To the best of my knowled On the basis of examination and manner stated.	dge, death occurred and/or investigation,	at the time, date and pla in my opinion, death oc	ice, and due to the cau ccurred at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
h	To the Comp	Ž	29b. Signature and title of certifier	MD	290	P1981 of Mary (2	Date signed (Mont.)	n, Day, Year) -2006
7	`		30. Name an address of a son who complete the son w	te use of death (Item 23a	a) (Type, Print) YURSUM (of Maryl	and Med	decal Co	Cutch
1	Sta Registra		31. Date filed (Month, Day, Year) APR 2 0 2006	32 Registrar's Signature	Agastes	0 0			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 9:45an Year Month **Physician** FREDERICK MOORE RAYMOND Q 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ROSEDALE FRANKLIN SQUARE HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 3-7-1920 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days Hours Months 1 XM 2 □ F 218-07-5514 86 Yrs MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State or 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 XNo ROSEDALE BALTIMORE MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21237 U.S.A. 1813 GREEN CASTLE DRIVE Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 5 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHTTE 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) BETHLEHAM STEEL SUPERVISOR 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Depertment of Health and Mental Hy Important: If Item 27 is marked oth eny lightly or other traumatic even once. Be (HEINDL) MARGARET MOORE FREDERICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21237 ROSEDALE, MD 1813 GREEN CASTLE DRIVE MARY J. MOORE/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-2006 BALTIMORE, MD HOLY REDEEMER CEM. 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service License 21237 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed anding physicien and use es the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Division 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier physician owende 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) delphia RD. Suite 300 BAGO MD 21237 KCOIN Schendel MD 9114 Philadelphia RD. Suite 300 BAGO MD 21237 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006

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			For State Registrar	Otate of Mai		rtificate of			leg. No. 0 0	12456
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4	/Medic Examin	175	4a. Facility Name (If not institution, give	Street and number)		4b. City, Town, o	TIMORE	1	4c. County of N/A	Death
	Funeral	-	5. Social Security Number 6. S	7. Age ('In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	Birthplace (State or Foreign Country)
	Director		217 36 0000	□M 201 6	5 Yrs.	Michael Bays	110010	Aug. 12	, 1940	West Virginia
	land w		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Le	ocation				10d. Inside City Limits
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	172 hours after death with the Maryland "natural", or Itema 23a or 28a-f ehow valcal Executer reast be notified at	Completed by Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	23a	rai	1463 Gordon Dr				061		U.S.	American India
	itema itema	une	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🖾 No	er in U.S. 13.	Was Decedent of H If Yes, specify Cub-	dispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black,	American Indian, White, etc.
336	urs aft	by F	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	White
2-0	72 ho	ted	15. Decedent's Ec	lucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most of wor	rking	16b. Kind of Busi	ness/Industry
2	- 1 39	mple	Elementary/Secondary (0-12)	College (1-4or 5+))	<i>DO NOT us</i> e retired er – Opera			Taver	'n
2	filed v Hygie ther t	CO	10 LII 17. Father's Name (First, Middle, Last)		OWITE	oper.		ne (First, Middle,	Maiden Sumame)	
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ary	shou and M mar umat	-	19a. Informant's Name/Relationship (ing Address (Street				
	of Health of Hea		Earl Murphy Jr.	/ son		Woodsedge				land 21643
ore	ges 1 t of H if iter or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disponentery, cre			Date	20c. Location - C	nie, Maryland
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Ba	permit. Pages 'Department of H Important: If the eny injury or of		Many M	2 amines	//		nie Highw	ay Balt	imore, M	aryland 21225
3/4	and the		23a/Part1. Enter the disease, or com- shock, or heart failure. List only	lications that caused the cause on each tine	he death. Do not en	iter the mode of dyi	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
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K 68	leath certificate attending physi	Physician/Medi	IF FEMALE:	23c. If yes, outcome or	f programmy				224 D-1-	of delices.
Box	attend for us	slan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у		23d. Date Mont	
P.O.	that the ded by the detached	hysic	1 Yes 2 No 9 Unknown	9□ Unknown						
	res that igned b	by P	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gr	ven in Part I.			oute to the cause of death?
ord	w require been signature	ted						101	res 2□No (Probably 4 □Unknown
ecc	law r nas be e 2 sh	Completed						24a. Was autop	osy pr	ere autopsy findings available or to completion of cause of ath?
al H	sician: The law certificate has l irector, page 2 s							1 Tes	212No 1	Yes 2□No
Σ	ysiclan: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: Inpatien	t 2 ER/Outpatie	ent 3 DOA Ot	hac	ath <i>(Check only o</i> Home 5 □ Resid	ine) dence 6 □Other	(Specify)
of	er th	n; To	27. Manner of Death	28a. Date of Injury (Month, Day				7-	now injury occurre	
Sior	endin sath. or: Aft he fur	atio	Natural 5 Pending 2 Accident Investigatio	n		M 1	Yes 2 No			
Division of Vital Records,	or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	y · At home, farm, s (Specify)	treet, factory, office		28f. Location (S City or Tov		r or Rural Route Number,
	spitel ours a veral [29a. Certifier 1 Certifying Pl	nysician: To the best of	my knowledge, dea	th occurred at the t	ime, date and plac	e, and due to the	cause(s) and man	ner as stated.
	To the Hospitel or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medicai	(Check only 2 Medical Example)	niner: On the basis of and manner stat	examination and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place, ar	nd due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	1701-7	. \		se number		-	(Month, Day, Year)
	0		, 3000 /	INTER			3001		APRIL, 18	5,2006
	10		30. Name and address of person who RACHAD JALIL	completed cause of de	ath (Item 23a) (Type	VER STRE	ET, BAL	TIMORF		
i.	C+	ate	31. Date filed (Month, Day, Year)					10110		
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			1 - For State Registrar	State of Ma		epartm Certific			ınd M		giene	06	12457
			1. Decedent's Name (First, Middle, Las	it)						2. Date of De	ath		3. Time of Death
	Physic /Medi		John E. Musgrove							Month April	13, 2	006	11:13A M
	Exami		4a. Facility Name (If not institution, give	street and number)		4b. C	ity, Town, o	r Location of	f Death		1	nty of Death	
			Shady Grove Adve				ockvi				Mon	tgome:	ry
	Funeral		Social Security Number 6. Social Security Number	9x 7. Age	(In yrs. last birth	Mont	der 1 Year	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h v, Year)	9. Birth	nplace (State or Foreign
	Director		228-62-9955 Usual Residence of Decedent	XIII ZU		rs.				May 11			yland
	land ow		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
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	r 28a	Director	Maryland Montgom 10e. Street and Number	ery	Germant		Zip Code				10g. Citizen	of What Cou	
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	within 72 hours after death with the Maryland ene. than "natural; or Iteme 23s or 28s-f show ha Medical Examinar market.	Funeral	11. Marital Status	12. Was Decedent E	ever in U.S.			ispanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	Unite		tes ican Indian,
စ္	after or Ita	F	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X N	0				Puerto I	Rican, etc.)	E	lack, White	, etc.
8	ours Fal',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 L Yes	2 X No	Specify:			Spe	city: WI	hite
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a)	1 an Heal tem 2		Gaither E. Musgrov 20a. Method of Disposition	e, Jr./Bro	20b. Place of D			y, Loi	-	South	20c. Locatio		
<u></u>	ages int of t: If it		1 ☐ Burial 2 🛣 Cremation 3 🗆	Removal from State	cemetery,	crematory of	r other plac	θ) A	pril	20,	ZUC. LUCATIO	ii - City or 1	OWII, State
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23s or 28s-f show any fujury or other traumatic event, the Medical Examinat must be notified at ance.		4 □ Donation 5 □ Other (Specify 21. Signal - Fineral Service License		Montgo	orium,	Inc.	a of Coulity	2006		Bethe	sda.	Maryland meral Home
Ba	Departing Department of the policy of the po		in the state of th	-		Rocky	rille,	Inc.	30	0 West 20850	Montgo	mery	neral dome, Avenue
			23a. Part1. Enter the disease, or comp	lications that caused	MUU8U3	Rocky	ville,	Mary	land	20850	<u>-2805</u>		
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line	θ.	CONTOL THE H	ode of dynn	y, suciras c	ardiac oi	1 tospilatory all	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Dancre									days
П	Examiner			* Due to (or as a	consequence of	:							1
	إلكا	er		b. Due to (or as a	nonsequence of								
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury										
,	exector and and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)	:						-	
8/60,	icate be executed physicien and s the burial-transit	dical		d									
9	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	led		J									
X R R	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy	о (П					23d. E	ate of deliv	erv
	deat e att	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 2 4☐Pregnant at t		3 ☐ Ectopic 5 ☐ Other					N	Month	Day Year
J.	by the a	Physici	9 Unknown	9□ Unknown									
	w requires that been signed b should be deta	by F	Part II. Other significant conditions co	ntributing to death but	t not resulting in ti	ne underlying	g cause give	n in Part I.		23e. Did to	bacco use co	ntribute to t	he cause of death?
ב	aquir en si buld l	ed	obesity							1 🗆 Y	es Who	3 🗆 Prob	oably 4 🗆 Unknown
ပ္ထ	e law re has be ge 2 sh	ple	Sleep apnea							24a. Was a		. Were auto	opsy findings available
ř	The ate h	Completed	•						_	autops perfor	med?	prior to co death? 1 Yes	mpletion of cause of
Vital Records,	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?					26. Place o	of Death	Check only or		1 1 103	250,100
	Physic this ce al dire	2	1 Yes 2 No	Hospital:	t 2 ER/Outpa	atient 3	OOA Othe			e 5 🗆 Reside		ther (Specif	5v)
C	ding Ph h. After th tuneral		27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim		28c. Injury Work	at		8d. Describe h			,,
<u>0</u>	uttendi death. ctor: A y the tu	catle	2 ☐ Accident investigation			М		es 2 □ No	0				
DIVISION OF	re re d	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y · At home, farm (Specify)	, street, fact	ory, office		28	Bf. Location (Si City or Town	reet and Nun	nber or Rura	al Route Number,
	ital o irs afi rel Di			1									
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier Conscious 2 Medical Exami	sician: To the best of	my knowledge, o	eath occurre	ed at the time	e, date and	place, ar	nd due to the c	ause(s) and r	nanner as s	tated
	vithin 2. To the I	Med		and manner state	ed.					a at the time, t	ate and place	, and due it	o the cause(s)
	T WE O	-	29b. Signature and title of certifier Pluce J.	11=0	MD	2	9c. License	number		2	9d. Date sign	ed (Month,	Day, Year)
							D5	4738	5	/	4pril	10,2	2000
7	1)		30. Name and a ress of person who co	mpleted cause of dea	ath (Item 23a) (Ty Medica	pe, Print)	to-	Delin	. 0	ockvill	e m	n 7"	20 50
1			Alicea T. Mistra			1 0	- 400-7	IN I VE			, , ,	v ac	0 30
I	Sta Registra		31. Date filed (Month, Day, Year) APR 2 0 2	32. Reigistrar	s signature	Rocal	B						

				1_ For State	State of M	aryland / [ent of H	lealth and M	lental Hy	giene	gible.	2	58
				Registrer 1. Decedent's Name (First, Middle, Las.	()		Ochano	ate or	Death	2. Date of Dea	Reg. No.		3. Time o	d Death
		Physici /Media			Carl Eu	igene Mc	Creary	, Jr.		Month April	Day	2006	6:14	P M
•	7	Examir	ner	4a. Facility Name (If not institution, give			4b. (City, Town, o	or Location of Death		4c. Cour	nty of Deat	h	
				Suburban Hospita				Bethes				gome		
	п	Funeral		5. Social Security Number 6. Se	×	ge (In yrs. last bir.		ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) December	h v, Year)	9. Birtl	nplace (State ountry)	or Foreign
		Director		172-36-5839 Usual Residence of Decedent		60	TIS.			December	16, 194	5 Penn	sylvan	1a
		land ow		10a. State 10b. County		10c. City, Town	n or Location						10d. Inside C	ity Limits
		Mary	Ď	Maryland Montgome	rv	Rock	ville						1 🗆 Yes	2 X No
		28a	rec	10e. Street and Number		ROCK		. Zip Code			10g. Citizen o	of What Co	untry?	
		h with	Funeral Director	11414 Hounds Way				20	0852		United	Stat	es	
		death	Jer	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was D	ecedent of H	Hispanic Origin? (Spean, Mexican, Puerto			ace - Ame	rican Indian,	
	9	after or fte	Ē	1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give	No		specify Cuba as 2 No	Specify:	Hican, etc.)		lack, White		
	21215-0036	72 hours after death with the Marylan "naturel", or theme 23s or 28s-1 show idical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		1016	35 267140	эрвспу.		Spec	ony: V	Vhite	
	5-(72 h 'natu	Completed	15. Decedent's Edi (Specify only highest grad	ucation de <i>completed)</i>	16a.	Decedent's (Give kind o	f work done	during most of works	ing	16b. Kind of Unite			
	121	within han	ᇛ	Elementary/Secondary (0-12)	College (1-4or			T use retired	d)		Posta	-		
	2	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)	т	50	upervi	SUL	18. Mother's Name	/First Middle				
2	au	ntal led o	Be	Carl Eugene McCre	oru Cr					eth Rab		arrie)		
181	Maryland	mark mark	은	19a. Informant's Name/Relationship (T	•	19b	Mailing Add	rass (Street	and Number or Rura			m State 2	in Codel	
	Ma	ith ar ith ar 27 is trau		Mary Elizabeth McC		1			Way, Rock					
9	ē,	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23s or 28s-f ehow other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition		20b. Place of	Disposition	(Name of		late	20c. Location			
90-11-	Baltimore,	permit. Pages 1 a Dep. rtment of He important: if item any njury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		Montgome	y, crematory erv Crem		1225		Rethes	sda. 1	Marylar	nd
1	===	mit. I		21. Signature of Funeral Service Licens			-					_	_	
7	ä	F 9 E 8		/ Markette Sa	exist	M01305	7557 W	isconsi	ess of Facility Tiphrey Funer In Avenue, B	ai Home/I ethesda,	setnesda Maryland	-cnevy d 20814	4-3501	Inc.
	i			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	d the death. Do r							Approximat Interval Bet	te
		Physician	2 Y	Immediate Cause (Final disease or condition		ary Embo							Onset and 10 Min	Death
		/Medical		resulting in death)	a	a consequence							10 1111	
		Examiner		Sequentially list conditions	Lung C	ancer							4 Mont	hs
		₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопавдивіїся (oi).							
		e be executed rsician and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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	68760,	leath certificate attending physi I for use as the b	g		d									
	×	certifi oding ise as	₩	IF FEMALE:	23c. If yes, outcome	of pregnancy					224 5	nto of dollar	-00/	
. \	Bo	atter I for u	clar	in the past 12 months?		2 Fetal death	3 ⊟Ectop 5 ☐ Other	ic pregnancy	1		1	Date of delin Month	,	Year
2	o.	The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	Physician/Medio	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9□ Unknown			(
4	υ, σ	s that ned b	by P	Part II. Other significant conditions co	ntributing to death b	out not resulting in	the underlyi	ng cause giv	en in Part I.	23e. Did to	bacco use co	ntribute to	the cause of c	death?
61	ī	w requires t been signe should be	Pa							1 ∑ Y	es 2□No	3 ☐ Pro	bably 4 🗀	Jnknown
\sim	တ္တ	law re as bee 2 sho	Completed							24a. Was	an 24b	. Were aut	opsy findings ompletion of c	available
>	H	The la	E							autop perfor 1 Yes	med?	death?	ompletion of c 2 □ No	ause of
V	ital		Be C	25. Was case referred to medical					26. Place of Death	10.		1 1 103	2010	
4	Ž	Physician: r this certifica ral director, i	ToE	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	ent 2 🕅 ER/Ou	tpatient 3	DOA Oth	er: 4 🗆 Nursing Ho	me 5 🗆 Resid	ence 6 🗆 O	ther (Spec	ify)	
W	0 _	ding Pl		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. T	ime of	28c. Injun Wor	y at k?	28d. Describe h				
15	Sio	Attending it death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			М		Yes 2□No					
0	Division	or Att	Certification;	4 Homicide determined	28e. Place of Inj building, et	iury - At home, fai c. <i>(Specify)</i>	rm, street, fac	ctory, office		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rui	ral Route Num	iber,
2		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		200 Cartifier M Cartiful To			1 - 0	05,50						
4	•	24 ho Funi	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exemi one)	sician: To the best iner: On the basis o and manner st	f examination and	, death occur Dor investiga	red at the tin tion, in my o	ne, date and place, a pinion, death occurr	and due to the o ed at the time, o	ause(s) and r late and place	manner as a, and due	stated. to the cause(s	5)
		Mithin 2 Fo the	Med	29b. Signature and title of certifier	and mariner str			29c. Licens	e number	1	9d. Date sign	ned (Month	Day, Year)	
		r s r ō		lavellen A	1000	escul	4/)H37	188		pril 1			
	_	7	0	30. Name and address of person who o			Type, Print)		100	A	hrit I	⊥, ∠∪	00	
	7	U	1 8	William B. Swann,				orget	own Road,	Bethese	da, Mar	rylan	d 20814	4
		Sta		31. Date filed (Month, Day, Year)		ar's Signature	Beek	e de						

				partment of Health and Mertificate of Death	lental Hygier		12459
Ä,	Physici	an	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
ı	/Medi	cal	Gordon Norris			4 2006	240 PM
\mathcal{F}_{i}	Examir	ner	4a. Facility Name (If not institution, give street and number) University of Maryland Medical Chive-	4b. City, Town, or Location of Death Baltimore, Mi		4c. County of Death	1
	Funeral	1,00	Social Security Number 6. Sex 7. Age (In yrs. last birthda)) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		place (State or Foreign
, p	Director		212 30 5949 1 DXM 2 F 73 Yrs.	Months Days Hours Min.	Jan. 19,	1933 Ma	ryland
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
	Mary B-f eh	tor	Maryland N/A Baltin	more			1 X Yes 2 ☐ No
	or 28	Direc	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	s 23s	eral	3926 Pennington Avenue	21226		U.S.	
10	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow alteal Examinar must be notified at	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Bican, etc.)	14. Race - Amer Black, White	
93	ours a	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whi	te
5-0	d within 72 hours after death with the Marylan Jone. r than "natural", or items 23s or 28e-f ehow the Mydical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki	ing 16b	Kind of Business/Ir	ndustry
12	within lene. than "	duic	Elementary/Secondary (0-12) College (1-4or 5+)	Carpenter		Constru	ction
br	Hyg Hyg ent,	BeC	17. Father's Name (First, Middle, Last)	-	e (First, Middle, Maid		
ylar		To E	Bernard Norris	Kathe	eryn Kiel		
Maryland 21215-0036	nd 2 should th and Mer 27 te marke treumatic			ling Address (Street and Number or Rura Pine Drive Pasa			
	1 an Heal em 2	1	20a. Method of Disposition 20b. Place of Disp	osition (Name of	adena, Mar	Location · City or T	
MO	Pages nent of int: if it		Ligitation 2 Defendation 3 Deemoval from State	Weteran Cem. 4/19			
Baltimore,	permit. Page Department of Important: If eny injury or once.			22. Name and Address of Facility Go			
	80 E 2 9			001 Ritchie Highwa	-	ore, Mary	land 21225
Ą			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) A Due to (or as a consequence of):	tartion			2 weeks
	Examiner		Leconery Art	tarction en Disease			
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	and I-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	licate be executed physician and s the burial-transit	cal E	255 15 (21 25 2 55),154 55),155 51),				
9	tificate g phy as the	Medic	U				
Вох	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	
P.O. I	he de	yslc	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
	res that t signed by be detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	w requires been sign should be	ed b	cerebrovascular accident		1 🗆 Yes	2 □ No 3 To Froi	oably 4 Unknown
ecc	e law re has be je 2 sho	Completed	Clustridium difficile colitis		24a. Was an autopsy	24b. Were auto	ppsy findings available mpletion of cause of
E E	cate h		carotic steassis		performed	death?	2 No
<u> </u>	eicien	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ Yi Hospital: 1 ☑ Inpatient 2 □ FR/Outnatie	26. Place of Death	25 10		
of	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	THE SELECT 4 HOUSING HOIS	ne 5 Residence 28d. Describe how in		(y)
joi	endin sath. or: Aft he fur	atlo	2 Accident investigation	M 1 Yes 2 No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ite)	al Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certific Within 24 hours after death. Within 24 hours after death. You the Funeatal Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cause	(s) and manner as s	tated
	he Ho in 24 h he Fui pletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ovestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to	the cause(s)
	To 1 To 1 Com	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month,	•
	1241		yonanan tenbel, MI)	P18587		April 1	1,2006
1	00		30. Name a Maddress of person who completed cause of death (Item 23a) (Type Jonathan Fenkel, Mi) 27 S.	reene St., Ste N3E	10, Bult	am som	21201
	Sta		31. Date filed (Month, Day, Year) 32, Registrar's Signature	outes	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	
1	Registr	ar≀	APR 2 0 2006 Barre As A	NES!			

/Medic	an	State Registrar Amend Item #1 Per I	L. O'Do	onoghy	e e	4.6	2. Date of Dea Month	Reg. No. Day	Year	3. Time of Death
Examine		la. Facility Name (If not institution, give street and number				Location of Death			2006 ty of Death	11
Lxammi		THE JOHNS HOPKINS HOSPITAL	,	1	BALTIMORE			40.00011	ty or Death	
Funeral			ge (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day	Year	9. Birthp	place (State or Foreig
Director		214-38-1334	73	Yrs.	MOTHETS Days	Hours Min.	Jan. 20	,1933	Cour	MD
* -	}	Usual Residence of Decedent 10a. State 10b. County	10c, City, T	own or Locat	ion					Od Inside City Limit
28e-f ehow	ក	MD Baltimore								0d. Inside City Limit 1 ☐ Yes 2 X N
or 28e-f ehov be notified at	Director	10e. Streel and Number	Ke	isters	10f. Zip Code			10g. Citizen of	What Cour	
		200 Cherry Valley Road			,	136		og. Omzon o		wy:
ame 2	Funeral	11. Marital Status 12. Was Deceden Armed Forces	t Ever in U.S.	13. Wa		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	14. Ra	USA Ice - Americ	an Indian,
0 0	교	1 Never Married 2 Married 1 Yes 2]No	10	es, specify Cuba Yes 2∭2 No		Hican, etc.)		ack, White,	etc.
ural.	d b	3 ☐ Wildowed 4 ☐ Divorced Year or Dates	1953-56	5	7 105 2 <u>7</u> 1 NO	эрвспу.		Spec	Whi	te
nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16	6a. Deceden (Give kin	t's Usual Occupa d of work done o	ation <i>furing</i> most of work)	ing	16b. Kind of	Business/In-	dustry
than than	ᇎ	Elementary/Secondary (0-12) College (1-4or			ty Guar			T7 1	l	
ent.	Be C	7. Father's Name (First, Middle, Last)		Securi	Ly Guar	18. Mother's Nam				ecurity
ked ic ev	10 B	David Allen O'Donoghue					thy Mary			
m m	_	19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailing A	Address (Street a	nd Number or Run				Code)
artra		Philip A. O'Donoghue So				lley Road				
i i i		0a. Method of Disposition 1 XX Burial 2 □ Cremation 3 □ Removal from State	20b. Place	a of Disposition	on (Name of ony or other place			20c. Location		
ant: I		4 □Donation 5 □ Other (Specify)				t.Cem 4	/24/06	Owing	s Mil	ls, MD
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", eny injury or other traumatic event, the Nadical Exa once.		21. Signature of Funeral Service Licensee		22. N	ame and Addres	s of Facility	11824	Reist	erstov	vn Road
7 E 2 9	4	Tany of time		E1	ine Fun	eral Home	Reist	erstown		
		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. D line.	o not enter th	he mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between
sician	1	Immediate Cause (Final disease or condition a. Anoxic assuring in death)	שונים וים	nury						Onset and Death
edical miner		Due to (or as	s a consequenc	ce of):						
	<u>.</u>	Sequentially list conditions, b. Due to (or as	s a consequence						- 1	2 2045
ınsit	Examiner	cause. Enter Underlying Cause (Disease or injury	, 4 001130440110	30 01).						
icien and burial-transit	EX S	hat initiated events c	s a consequenc	ce of):						
physicien the buria	dical	d								
	Jed -	F FEMALE:								
tendi	an	23b. Was decedent pregnant 23c. If yes, oulcome	e of pregnancy 2 Detail dea	ath 3∏Ect	opic pregnancy				ate of delive	ry
m 2	SICI		I time of death		her (specify)			М	onth	Day Year
bed i	Ē,	3 - OTIKNOWN								
d by the detached	- 1	art II. Other significant conditions contributing to death t	out not resutting	g in the under	Tying cause give	n in Part I.				e cause of death?
P Be	6						1 76	s 2 XNo	3 L Proba	ably 4 □Unknow
been signed by the attending p should be detached for use as	ered D)						04- 146		prior to con	sy findings available appletion of cause of
P Be	Inpleted Dy						24a. Was a autops		death?	2□ No
ete has been sign page 2 should be	Сотріете						autops perform 1 Yes 2	ned?	1 ☐ Yes	
ertificete has been sign ector, page 2 should be	De Completed	5. Was case referred to medical examiner? Hospital: Hospital:			0.5	26. Place of Death	autops perform 1 Yes 2	ned? 2 X No e)	1 🗆 Yes	
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			For State Registrar			of Ma	rylan				ealth a Death	nd M	ental Hy	Reg. No.) () ()	12461
	Physicia	an	Decedent's Name	_									Amonth Aoril	Day	Year	3. Time of Death
	/Medic	al	Dary1 4a. Facility Name (#		Pedde	number)			4b City	Town or	Location of		Horil	15 4c. C	200 (ounty of Deat	4.
	Examin	er	BACTIMOR		15 HINGTE		TEDIO	AL CET	1				NIC			2012262
	Funeral		5. Social Security Nu		6. Sex	7. Age		last birthday	+	r 1 Year	If Under 2 Hours	4 Hrs.	8. Date of Bir (Month, Da	th Year	9. Birti	hplace (State or Foreign untry)
	Director		364-70-48		12XM 2□ F		47	Yrs.	Months	Days	Hours	IVIII I.	May 2,	1958	Mic	higan
	and and		Usual Residence of 10a. State	10b. County			10c. City	y, Town or L	ocation							10d. Inside City Limits
	the Marylan r 28a-f ehow notified at	tor	Maryland	Anr	ne Arunde	1	S	Severn								1 ☐ Yes XX No
	death with the Maryland ma 23a or 28a-f ehow Fmust be notified at	Funeral Director	10e. Street and Num	nber					10f. Zi	p Code				10g. Citize	n of What Co	untry?
	th wit	alD	1848 I	Dove Co	ourt					21	144			Uni	ted St	ates
		nuel	11. Marital Status			Forces?		S. 13.	Was Dece If Yes, spe	dent of H	ispanic Orig n, Mexican,	in? (Spe Puerto F	cify Yes or No Rican, etc.)	D- 14	Race · Ame Black, White	
36	hours after turel', or ite	by F	1 Never Marrie 3 Widowed		ied 1 ⊡ Ye If Yes, Year o	s 2⊠Ne Give Dates	0		1 🗆 Yes	2 ☑ No	Specify:			s	pecify:	White
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and bu	ould be fil Mental H arked oth	Be	17. Father's Name (A										<i>(First, Middle</i> L1son	, Maiden S	umame)	
edde,	2 should be filed within and Mental Hygiene. is marked other then aumatic event, Ira M	ဥ	19a. Informant's Na					19b. Mail	ina Addres	s (Street a			Route Numb	er. City or	Town, State, 2	Zip Code)
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J. e.	ss 1 ar of Hea item		20a. Method of Disp		a C.D.	- 01-1-	20b. P	lace of Disp	osition (Na	me of other plac	e) A	Apri ⁹	ate 19,	20c. Loca	tion - City or	Town, State
, E	Pages ment of ant: if it ury or o		4 Donation		3 □Removal fro pecify)	m State	G1e	n Hav	en Me	m. P1	1	_	006	Glen	Burnie	, MD
Baltimore,	permit. Pages 1 Depertment of H important: if iter eny injury or oth		21. Signature	neral Service	bay			K ²	2 Name a irkle 21 Cr	nd Addres y-Rus ain	ss of Facility Idick Iwy . S	Fune	glen H	me P. Burnie	A. _{MD} 2	1061
			23a. Part1. Enter th shock, or hear Immediate Cause (I	t failure. List	complications the only on suse of	nt caused in each line	the deatl e.	h. Do not er	iter the mo	de of dyin	g, such as c	cardiac o	r respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	1	aDue	to (or as a	consequ	uence of):	21	cer	AP	NBC				
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kl	and I-trans	Examiner	that initiated events resulting in death) L		c. Due	to (or as a	consec	nence of):								
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of Vital Records, P.O. Box 6	The law cate has I page 2 s	Completed	toi_I	mme	vale				<u> </u>				auto perfe	psy ormed?	prior to death?	completion of cause of
ital	ilcien: Th certiticate rector, pag	0	25. Was case referr	ed to medical							26. Place	of Death	1 ☐ Yes (Check only	2 No one)	1 105	2 NO
>	hyeici this ce al direc	To B	examiner?	No		☐ Inpatier	-	ER/Outpatie			4 LI Nur	sing Hor	ne 5□Res	idence 6	□Other (Spe	ci fy)
	ding Ph h. After th funeral	ino in	27. Manner of Death 1 XNatural	5 Pendin		te of Injury onth, Day	Year)	28b. Time Injury		28c. Injun World			28d. Describe	how injury	occurred	
Division	death.	Icat	2 Accident 3 Suicide	investig 6 ☐ Could r	not be	ace of Inju	ny - At ho	ome, farm, s	M treet facto		Yes 2 □ N	10	28f Location	Street and	Number or Ri	ural Route Number,
À	Hospitel or Attending Physicien: The law requires that the death certificate be executed 4.4 hours after death. Funerel Director: After this certificate has been signed by the estending physicien and tely filled in by the funeral director, page 2 should be deteched for use as the burial-transit	Certification:	4 🗌 Homicide	determ	bu	ilding, etc.	. (Specif	y)		ry, onice				wn, State)		nar route ramber,
	To the Hospitel or Attendi within 24 hours atter death To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 Certifyin 2 Medical	ig Physician: To Examiner: On the and m	the best of basis of anner stat	examina	wledge, dea tion and/or i	th occurrent restigation	at the tin	ne, date and pinion, deat	place, a	and due to the	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and	title of dertifie	r				25	c. Licens	e number			29d. Date	signed (Monti	h, Day, Year)
			Cu	ella	ML.	MI	>			D	005	991	9	AD	Del: 15	2006
	1.		30. Name and a dre	of person	who complet = c	ause of de	eath (Item	n 23a) (Type	Print)	1.1	1		11.			h 01005
	Sta	to	31. Date filed (Mont	th, Day, Year)	a. W. 32	. Aégistra	r's Signa	ture,	492	TITEL	UI	,	loin]	DOMN	m, a	D X1061
	Registr			APR 2	0 2006	Delen		13 19	STATE OF THE PERSON							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year VICKIE M. PRICE 5:45p Apr 15, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHN HOPKINS MEDICAL CENTER **BALTIMORE** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X □ F Director 219-86-8328 41 Dec 20, 1964 MARYLAND Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director MD **BALTIMORE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 3537 PELHAM AVENUE 21213 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done d life. DO NOT use retired) during most of working d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) **BANKING PROCESSOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WATUS PRICE BARBRA HARRIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 Is eny injury or other trau once. BARBRA PRICE Mother 1301 COLBURY ROAD BALTIMORE, MARYLAND 21239 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial ∕2 □ Cremation 3 □R€ oval from State ` 4 ☐ Donaylon /5 ☐ Other (Specity) 04/22/06 MOUNT ZION MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Miller's Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 Part1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aderocarcinoma METASTATIC Physician UNCHOWN disease or condition resulting in death) Mons /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) as the burialphysician Box 68760 Physician/Medicai the attending esn. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Š signad b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 ☐ Yes 2 ♣No X 2 2 No 1 Yes Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation M 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide A 24 hours. the Funerel Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 **RES-000** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 2 0 2006

ORIGINAL

MANISH ARORA 600 N. WOLFE STREET BALTIMORE, MARYLAND

			1 - For Amend Item#19a j	State of Mar Ber INF G	yland/ 854 4/	2576 Cer	utment 16 CC tificate	of He	alth ar <i>eath</i>	nd Menta		ene g. No.		12463	
*	Physic	an	Decedent's Name (First, Middle, Last) Dorothy		Dur					Mo	e of Death	Day	Year	3. Time of Death	_
Q.	/Medi	cal	4a. Facility Name (If not institution, give str	not and number	Pur	vey	4h Ciby 1	Four or I	ocation of [4	12		2006	14:00	VI
	Examir	ner	400 Millington Av					ltin		Jean		4C. C	ounty of Deatl	1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	oirthday)	If Under	1 Year	If Under 24	Hrs. 8. Dat	e of Birth	Vasal	9. Birth	nplace (State or Foreig	gn
	Director		001-24-4733	4 2 X F	74	Yrs.	Months	Days	Hours		nth, Day, –24– 3		0	MD	
	land land		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, To	wn or Lo	cation							10d. Inside City Limit	ıs
	Mary Lefeh	tor	MD NA		Balt	imor	e:							X OXYes 2 □ N	
	th the	Director	10e. Street and Number				10f. Zip	Code			10	g. Citize	n of What Co	untry?	_
	23a c	ralD	400 Millington	Ave Apt	306			2]	L223				U.S.A	•	
	d within 72 hours after death with the Maryland Jone. Ir than "natural", or teme 23a or 28a-1 show the Mudical Examiner must be notified at	Funeral		. Was Decedent Ev Armed Forces?	er in U.S.	13. V	Vas Decede f Yes, speci	ent of Hisp fy Cuban,	anic Origin Mexican, F	? (Specify Ye Puerto Rican, i	s or No- etc.)	14.	Race - Amer Black, White		
336	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 █ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1	□ Yes 🗶	X No	Specify:			S	pecify: p	lack	
21215-0036	2 hou		15. Decedent's Educa	tion	16		lent's Usual				1	6b. Kind	of Business/I		
21	within 7 ene. than "r	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)		life. E	kind of work OO NOT use	e retired)	ring most of	t working		-			
121	il Hygier other th		12th grade	na			Clerk					Leg	on		
Maryland	e d at b	o Be	17. Father's Name (First, Middle, Last)							Name (First, L Holm		aiden Su	ımame)		
IZ.	2 should I and Meni is marked	Ţ	Norman Blake 19a_Informant's Name/Relationship (Type	Print)	19	b. Mailin	a Address			or Rural Route		City or T	own State 7	in Code)	
	C		19a Informant's Name/Relationship (Type Lea Ethel Green (1 Leo Green Siste	sister)										Md 21108	ŀ
ore,	es 1 and 2 of Health of Itam 27 i		20a. Method of Disposition	and from Chate	20b. Place cemet	of Dispos	sition (Name	e of her place)		Date	2	0c. Loca	tion - City or 1	own, State	_
Ë	Pag ment ant: i		Murial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Arbu				L 4/	/19/06	P	rbu	tus,	Md	
Baltimore,	permit. Pages: Department of h important: if its any injury or of		21. Signature of Funeral Service Licensee	K. Ch	res)		Name and March					43C	0.Waba	sh Ave. 212	21!
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused th	e death. Do	not ente	er the mode	of dying,	such as car	rdiac or respir	atory arres			Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Lur	16	CI	ANC.	523						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence										
***	TEL Va	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence	of):									
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	,	1	/-									
· o	an an rial-tr	Exa	resulting in death) Last	Due to (or as a c	onsequence	of):									
8760,	icate be executed physician and s the burial-transit	dicai	d												
9	entific Jing pl		IF FEMALE:												_
Вох	that the death certified by the attending of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	If yes, outcome of 1 Live birth 2 [Fetal deat		Ectopic pre					23d	Date of delive	ery Day Year	
o.	the de y the iched	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant at tirr 9□ Unknown	ie or death	5	Other (spec	спу)						,	
٣,	requires that the een signed by th nould be detache	y PI	Part II. Other significant conditions contri						in Part I.	236	. Did toba	cco use	contribute to	the cause of death?	
Vital Records,	v require been sig should b	Completed by	· COPD Chrin	ric Obst	ructiv	re Pa	simor	lary	Dise	ase	Yes	2 🗆 N	lo 3□Pro	bably 4 Unknown	n
ecc	as b	plet	· Congestire hi	earl F	aila	re				24a	. Was an autopsy	2	4b. Were aut	opsy findings available	8
E E	The page	Con	· Mysertensic	in Co	ים זו נדרי	~	Aste	24	Dise	eare 10	performe	No	death?	empletion of cause of	
Vita	tician: Th certificate rector, pag	Be	25. Was case elerred to medical examiner?	-ia-li					6. Place of	Death (Check	only one)				
of	무 두 등	7.	1 192 5 140	pital: 1 Inpatient 28a. Date of Injury		utpatient Time of	3 DOA			ng Home 5				fy)	
on	ding th. After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y		Injury	м 28	c. Injury at Work? 1 □ Yes	2 □ No	280. Des	scribe how	injury o	ccurred		
Division of	Atten r deal ector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, f	arm, stre				28f. Loca	ation (Stre	et and N	umber or Rur	al Route Number,	
Ö	s afte	Cert	4 Hornicide	building, etc. (Specify)					City	or Town,	State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the funeral director, the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director, the funeral director director director directors.	Medical	29a. Certifier (Check only one) Continue 2 Medical Examiner	an: To the best of n : On the basis of ex and manner stated	amination at	je, death nd/or inve	occurred at estigation, in	the time, n my opini	date and ploon, death o	lace, and due occurred at the	to the cau time, date	se(s) and e and pla	d manner as s ice, and due t	stated. o the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	•			29c.	License ni				l. Date si	gned (Month,	Day, Year)	
			Musteur E	seg				D	46	071		4	+/14/0	6	
	3		30. Name and address of person who comp		h (Item 23a)	(Туре, Р	rint)		1	4	2			LD 21229	
100 m	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's	538 Signature	EDM	TOND	32	17VEA	NE P	MIT	mo	RE N	111129	_
+	Registr		ADD 9 0 20		No.	A.	SALL D	,							

Physic	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Medi	cal	4a. Facility Name (If not institution, give	Matthew J. P	4b. City, Town, or Location of Death	APRIL	17, 2006	12:55 A
Exami	ner	VA MARYLAND HEALTI		PERRY POTNT		4c. County of Dea	ıtn
Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	CECIL 9. Bir	thplace (State or Foreigountry)
Director		Usual Residence of Decedent	76 Yrs	s. Notation Bayon Hours	Mar 7, 19	930 8	So. Carolina
yland yland		10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limit
Ba-fst	ctor	Maryland N/	Ά	Baltimore			1 MYes 2 □ N
death with the Maryland ms 23a or 28a-f show	Funeral Director	10e. Street and Number 207 South Catherine Stre	aat	10f. Zip Code 21223	10g.	Citizen of What Co	
death ms 23	eral	11. Marital Status		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
after or Ita	/Fui	1 ☐ Never Married 2 🛣 Married	Armed Forces? 1 ☑Yes 2 ☐ No 1f Yes, Give 1951	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 XNo Specify:	Rican, etc.)	Black, Whit	
hours after tural', or Ita	d by	3 Widowed 4 Divorced	Year or Dates: 1953			Specify:	Black
in 72 n "nat	plete	15. Decedent's Edu (Specify only highest grad	e completed) (C	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16b	. Kind of Business	
d within giene. ar than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Boiler Operator		В	GE
be filed ntal Hygie od othar svant, II	Be	17. Father's Name (First, Middle, Last)	. D #	18. Mother's Name	e (First, Middle, Maid		
should nd Men marke umetic	2	Matthey 19a. Informant's Name/Relationship (Ty				Pyatt	
and 2 sho ealth and n 27 Is mu		,	, , ,	lailing Address (Street and Number or Rur 207 South Catherine Street I			Zip Code)
of Health of Health fitam 27		20a. Method of Disposition	20b. Place of D			Location - City or	Town, State
Pages nent of snt: If it, ury or o		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	ionioval itomi State		04/24/06	Owings I	Vills, Md.
permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked other than "natural", or itams 23e or 28a-f show any injury or other treumetic event, Ita Modeal Examiner outs be notified at 20ce.		21. Signature of Furneral Service Licens	1) Entra	Name and Address of Facility	LOi D	^	
		Cecco (l. ESTA	Estep Brothers Funer 1300 Eutaw Place Ba	ai Service, P. Altimore, Md 21	217	
		23a. Part1. Enter the disease, or compt shock, or heart failure. List only or Immediate Cause (Finaf	cations that caused the death. Do not not not cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
hysician /Medical		disease or condition resulting in death)	ALZHEIMER'S DIS				UNKNOWN
Examiner							
D #	Iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
xecute and II-tran	Examiner		Due to (or as a consequence of):				
cate be executed obysician and the burial-transit	dical E	L.					
tificate ng phys as the	ledic						
leath certifica attending ph for use as th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of del	,
the a	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		Month	Day Year
Ine law requires that the death certificate be executed to the bean signed by the attending physician and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions con	23e. Did tobacc	23e. Did tobacco use contribute to the cause of deat			
quires an sign uld be	ed by			1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Hunknow	
e faw requii has been s je 2 should	Completed				24a. Was an	24b. Were au	itopsy findings availab
ysician: Ine la is certificete has director, page 2	Com				autopsy performed 1 Yes 2	? death?	
rnysician: In this certificete ral director, pag	Be	25. Was case referred to medical examiner?	loonital.		Check only one)		
E = E	. To	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpa 28a. Date of fnjury 28b. Time	A	me 5 Residence		cify)
th. : After thi	tlon	1 Natural 5 Pending 2 Accident Investigation	28a. Date of fnjury (Month, Day Year) 28b. Timi Injur		28d. Describe how in	ijur y occurred	
spirel or Artends ours after death. laral Diractor: A filled in by the fu	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St.	and Number or Ru	ral Route Number,
rs after rat Dira							
	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ter: On the basis of examination and/or	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
nospite 24 hours Funaral tely filled	a	29b. Signature and title of entified	and manner stated.	29c. License number		Date signed (Month	
vithin 24 hou	Σ						
To the Tospiel or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer		1 Chandl	Sada W	D42800	7 -	RIL 17, 2	2006

5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	neon=
Medical Examiner 4a. Facility Name (If not institution, give street and number) **XONTHUEST** **HESPITH CENTER** **RANDALIS TOWN **British And County **County Number** **Social Security Number** **G. Sex** **T. Age (In vis. last birthday) **If Under 1 Year** If Under 24 Hrs. 9. Date of Birthday **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday) **T. Age (In vis. last birthday)	neon=
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5. Social Security Number 6. Sex 7. Age (In vrs. last birth/gay). If Under 1 Year If Under 24 Hrs. 9. Date of Birth	
Director 212-46-9980 1 M 2 F 55 Yrs. Months Days Hours Min. Dec. 5, 1950	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent	
Politicans	10d. Inside City Limits 1X Yes 2 □ No
Maryland N/A Baltimore 106. Street and Number 109. Citizen of W	
501 S. Fulton Ave. 21223 USA	na oomy.
STATE OF THE STATE	- American Indian,
U 1 □ Never Married 2KM Arried 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Specify: Specify:	White, etc. White
We get the state of the state o	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 Homemaker Own H	siness/industry
Homemaker Own H	ome
TO Fife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Piece 19. William H Morrison Minnie M.	·
The state of the s	Stolzenbach
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S Nancy L. Wills (Sister) 519 S. Fulton Ave. Baltimore MD 212	
Nancy L. Wills (Sister) 519 S. Fulton Ave., Baltimore, MD 212 20a. Method of Disposition 20b. Place of Disposition (Name of Disposition (Name of Disposition)) Date 20c. Location - Compared to Disposition (Name of Disposition)	City or Town, State
Description of the state of th	e, Maryland
10a. State 10b. County 10c. City, Town or Location Baltimore 10a. State 10b. County 10c. City, Town or Location Baltimore 10a. State 10b. County 10c. City, Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Town or Location Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimore 10c. City Amanic Baltimor	al Home
3620 Wilkens Ave., Baltimore, MD	
23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician / Medical Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
Examiner	
Sequentially list conditions, if any, reading to minimulate cause. Enter Underlying Cause (Disease or injury	
Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Customary Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
edicate be edicate be edicate.	
SO SE SE SE SE SE SE SE SE SE SE SE SE SE	of delivery
	h Day Year
Fart II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	Probably 4 Allaknown
De de de la la la la la la la la la la la la la	
autopsy pr	ere autopsy findings available or to completion of cause of ath?
25. Was case referred to medical examiner?	Yes 2 No
C F =	(Specify)
27. Manne Death 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurre	i
The state of the s	or Rural Route Number
building ata (Casaita)	or nural noble (valider,
29a. Certifier 1 1 29a. Certifier 29	ner as stated.
EEE B S CONTRACTOR	
29b. Signature and title of certifier 29d. Date signed 29c. License number 29d. Date signed 29c. License number 29d. Date signed	Month, Day, Year)
30. Name and address of person who complete cause of death (Item 23a) (Type, Print)	17, 2006
30. Name and address of person who complete cause of death (Item 23a) (Type, Print) ORIANDO B. CONTANT ON PHINDAILS TERM MEAN	TAL CENER
State 31. Date filed (Month, Day, Year) 32 degistrar's Signature APR 2 0 2006	Unimerca Sain Seatt

			1 - For State Registrar	State of Marylai	-	artment of rtificate of			giene Reg. No.	06	12466	
. where	Physic /Medi		1. Decedent's Name (First, Middle, Last, FRANK,)	PE	CUKI	ONIS	2. Date of Dea Month APRIL		2006	3. Time of Death 04-29 P M	
	Exami	ner	4a. Facility Name (If not institution, give HARBOR 1-5. Social Security Number 6. Security 12 8051	OSPITAL	. last birthday) Yrs.	4b. City, Town, GA If Under 1 Year Months Days		RE S. B. Date of Birt (Month, Date	h v. Year)	Cou	place (State or Foreign	
	Director		Usual Residence of Decedent 10a. State 10b. County	- 01	ity, Town or Lo	cation		Jan. 30	0, 192		ryland 10d. Inside City Limits	
	vith the Mary or 28e-f shi	Director	Maryland Anne Ar			-	1 ☐ Yes 2. Citizen of What Country? U.S.					
2121	d within 72 hours after death with the Maryland Jene. r than "natural", or tems 23a or 28e-f show The Medical Evanta or must be purified at	ted by Funeral	109 Doris Avent 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ĀYes 2 □ No If Yes, Give Year or Dates: WW	II	Was Decedent of f Yes, specify Cul	Specify:	Specify Yes or No- rto Rican, etc.)	. 14. I	Race - Ameri Black, White, ecity: Whi	etc. Lte	
	within iene.	Completed	(Specify only highest grad		(Give	kind of work done DO NOT use retire ntenance	during most of w	orking		ison Wa		
Maryland	ges 1 and 2 should be filed it of Health and Mental Hygir if Item 27 is marked other or other traumatic event,	To Be (17. Father's Name (First, Middle, Last) Vince:	me (First, Middle, cy Sczygo		пате)						
อ์			19a. Informant's Name/Relationship (Ty Margaret Pecukon 20a. Method of Disposition 1 ☑ Method of Disposition 3 ☐ F	is / wife	109 I	ng Address (Stree Doris Ave sition (Name of matory or other pla	enue I	Baltimore Date	, Mary		21225	
Baltimore,	permit. Pages Department of I Important: If Ite any Injury or of once.		4 Donation 5 Other (Specify) 21. Signatore of Funeral Service Licens	Ho	1 22	SS Cemet	ess of Facility	9/2006 Gonce Fur	neral	Servic	Maryland e, P.A. land 21225	
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.O. Box 6	The law requires that the death certifica te hes been signed by the attending ph page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al déath 3 🗆	Ectopic pregnand	·y			Date of delive	ery Day Year	
rds, P	quires that in signed b uld be deta	by	Part II. Other significant conditions cor HYPERTEMS		sulting in the ur	nderlying cause gi	ven in Part I.	23e. Did to			he cause of death?	
Vital Records,	10	Completed	DIABETES	>				24a. Was a autop: perfor	sy	b. Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of 2 12 No	
Ĕ	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		01	hac	ath Check only or				
on of	Jing After fune	tion: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	4 1401 Sirily	Home 5 Resid			y)	
Division of	el or Attending s after death. Il Director: After ed in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)				(Street and Number or Rural Route Number, own, State)			
	To the Hospitel or Attentwift and 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	sician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ation and/or inv	estigation, in my	opinion, death occ	urred at the time, d	ate and plac	ce, and due to	o the cause(s)	
)	T with	2	29b. Signature and title of certifier	uma Leys	3a Mi	O RE	S OOC		19d. Date sig APRIL	gned (Month,	2006	
Ù	16		30. Name and address of person who co	mpleted cause of death (Iter		Print) JOVER	ST	BALTIM	•	MD	21225	
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 2 0 2	32. Régistrar's Signa	ature	carles						

				For State	State of M	larylan		artment of H <i>rtificate of l</i>		fental Hy		11116	1	2467
				Registrar 1. Decedent's Name (First, Middle,	Last)			Timodio or I	Joann	2. Date of De				3. Time of Death
		Physici /Medio		David Charles	Piquado					Month April		ay Ye 2006	ar	02:30A M
	-	Examir		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4	c. County of E	eath	
				Suburban Hospi				Bethesd				Montgo		
		Funeral			5. Sex 7. A 1 ☑ M 2 ☐ F		ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year			ce (State or Foreign
		Director		214-60-6662 Usual Residence of Decedent		56	113.			July 2	2, 1	949 Wa	ashi	ngton, DC
		ehow		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d	. Inside City Limits
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		ith with the Maryla 23a or 28a-f ehovest be notified at	Slre(10e. Street and Number				10f. Zip Code			10g. C	itizen of Wha	Country	n
		ath w	le	14021 Teaneck T				20878				ited S		
		er de	une	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, V	American Vhite, etc	
	36	rs att	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 [X]Divorced	d 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			1 ☐ Yes 2 🖾 No	Specify:			Specify:	Whit	e
	Maryland 21215-0036	be filed within 72 hours atter death with the Maryland ital Hygiene. d other then "naturel", or iteme 23a or 28a-f ehow avent, I're Modical Examiter must be motified at	ted	15. Decedent's			16a. Dece	dent's Usual Occupa	ation		16b.	Kind of Busine		
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	<u>×</u>	2 should be for and Mental by ie marked of raumatic average.	70	Carl Piquado					Alice Re					
	Mai	12 st h and 7 ien traun		19a. Informant's Name/Relationshi				ng Address (Street a						,
		1 end Health tem 27		Maurice Pennisi 20a. Method of Disposition	L/Executor	20b. P	lace of Diene	Toodmeadown sition (Name of		Date	_	Hamps I Location - City		
	Baltimore,	permit. Pages 1 and 2 should bu Department of Health and Mental Important: If tem 27 is markental any injury or other traumatic an		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Gai	emetery, cre te of	matory or other place Heaven	* April	1 18,	C.4	1 C		MD
	ij			21. Signature of Funeral Service Li			Cemet	ery 2. Name and Addres	2006 ss of Facility Ro	bert A.	Pu	lver S _l mphrey	Fun	eral Home
	ä	Ded Personal		> Nowils	Burn	M00	803 Rc	ckville,	Inc. 300 Marvland	0 West 20850	Mon 1–280	tgomer: 05	y Av	eral Home, enue
				23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cause nly one cause on each	d the death	Do not en	ter the mode of dying	g, such as cardiac o	or respiratory a	arrest,		A	pproximate
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		/Medical Examiner												1000
30			٠.	Sequentially list conditions,	b. St	PS	15							48 hs.
3			Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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11	Box	eath certif attending for use a:	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			DEctopic pregnancy				23d. Date of		
7	O. E	ie dea the att	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown			Other (specify)				Month	Da	ay Year
	۵.	that the de ed by the detached	Phy	Part II. Other significant condition	s contributing to death	hut not resu	ulting in the u	nderhina cause awa	on in Part I	23a Did	tobacco	use contribut	a to the	cause of death?
0	ds,	law requires that as been signed to 2 should be deta	d by	Tatal	311 al 1 al 1 l	23e. Did tobacco use contribute to the c								
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DAVIC	Re	9 F W	Completed							auto	psy ormed?	prior deat	to comp	letion of cause of
0	ta		Be Co	25. Was case referred to medical	-				26. Place of Death	1 ☐ Yes		ال ا	Yes 2	X No
٥	\leq	Physician: r this certitic ral director,	ToB	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Anpat	ient 2 🗆 I	ER/Outpatier	nt 3 DOA Othe				6 Other (S	Specify)	
0	0	Jing Ph J. After th funeral	L:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o	f 28c. Injury Work		28d. Describe				
7	Sio	Attending r death. Actor: After	atle	2 ☐ Accident investiga	tion		,		Yes 2 □ No					
PlanADO	Division of Vital Records,	l or Atten atter deat Diractor:	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of in	ijury - At ho itc. <i>(Sp</i> ec <i>if</i> y	me, farm, st	reet, factory, office	1	28f. Location (City or To			r Rural R	loute Number,
10		Hospital		29a, Certifier 1 Certifying	Physician: To the has	cal mor beau.	ula el vá	C. Danis served and their state	a data and size	and don't retain	Mark Control of Control	De namero de como o		4
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical E	xaminer: On the basis and manner s	of examinat	ion and/or in	vestigation, in my op	pinion, death occurr	ed at the time,	date ar	nd place, and	due to th	e cause(s)
		To the within 2. To the Complete	Me	29b. Signature and title of certifier	110	Δ	0	29c. License		_	29d. D	ate signed (M	onth, Da	y, Year)
		1		> 25 tisa	MASCAN	o M	V	Doc	06243	S	41	11/	20	06 2085t
	į	D		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type,	Print)	aton	8-5	n.,	.00. 1	10	208Th
	1	V		31. Date filed (Month, Day, Year)	1507449	rar's Signal	1715	Medili	Conto of	, ROC	N	cu,/	リリン	0000
		Sta Registr		APR 2 0	2006	nai s signal	K A	oseli						

			1 - For State RegistrarAment Item	State of M							•	giene Reg. No.	U 6	12468	3				
	Physici		Decedent's Name (First, Middle		Robinso			-		2. Date of De		006 Year	3. Time of Dea 8:00 a	ith M					
	/Medio Examir		4a. Facility Name (If not institution		er)	4b. City, Town, or Location of Death Baltim					4c. County of D			eath N/A					
	Funeral Director		5. Social Security Number 218-36-1525	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yr 6	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug 1	y, Year)	9. Birthplace (State or Country) Maryland		eign				
	Maryland 6-f ehow illied al	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local Maryland N/A						ltimore					10d. Inside City Lir 1 Yes 2 ☐					
	th with the 23e or 28 pst be no	Funeral Director	10e. Street and Number 601 Wyanoak Avenu	le			10f. Zip Code 21218					10g. Citizen	of What Cou	•					
9003	72 hours after death with the Maryland natural; or Items 23e or 28e-f ehow idical Exertiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🗷 Divorced	If Yes, Give Year or Date	is? ☑No		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri □ Yes 2⊠ No Specify:			acify Yes or No- Rican, etc.) 14. Race- Black, Specify:		Black, White	American Indian, White, etc. Black						
Maryland 21215-0036	d within jiene. r than "	Completed		t's Education st grade completed) College (1-4d)	or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired) Worker			t of worki	ng			ness/Industry Will Industries						
yland	nd 2 should be filed Ilth and Mental Hygi 27 ie marked other r treumatic event, II	To Be (ph Robinson								sy Johns	on						
e, Mar	is 1 and 2 sh of Health and item 27 ie m other treum			Alleyne Jones Friend		- Indi	39	43 Frisi	by Stre			Maryland	21218						
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	ipecify)	- 1	-	zion Ce	ther place emeter	у	4/21/ 	72006 14/18/06	20c. Location	-	Maryland					
Bal	Dermi Depa Impo		21. Sign were of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P.A. 1300 Futaw Place Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do notenter the mode of dying, such as cardiac or respiratory arrest, Approximate																
	Physician /Medical Examiner		shock, or heard failure. List Immediate Cause (Final disease or condition resulting in death)	aS	line.	equence of):			. U.S.					Interval Between Onset and Death)				
8760,	cate be executed physician and the burial-transit	Physician/Medical Examiner	cai Examiner	cai Examiner	cai Examiner	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		equence of):				0					
P.O. Box 68	death certifi e attending id for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 □ Fe at time of	tal death 3	Ectopic pro						Date of delik	ery Day Year					
- 10	sign d be	by	Part II. Other significant condition	sulting in the u	ng in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of									
Vital Records	The law ate has b page 2 s	Completed	0,49	Dement	ra						24a. Was autor perfo		b. Were autoprior to condeath?	opsy findings availa impletion of cause	able of				
ō	tending Physician: Theath. loath. tor: Atter this certificate the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner eath 1 tural 5 Pendir 2 Accident investi	Hospital: 1 Inpa 28a. Date of It (Month, It	-	⊒ ER/Outpatier 28b. Time of Injury		Bc. Injury Work	n 4 □ Nu	rsing Hon 2	(Check only one 5 Tesion 128d. Describe I	dence 6 🗆 (fy)					
Division	or At ifter c Direction by	Certification:	3 Suicide 6 Could 4 Homicide determ	not ho							28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examin	nowledge, death nation and/or in	occurred avestigation,	at the tim in my op	e, date an inion, dea	d place, a	and due to the ed at the time,	cause(s) and date and plac	manner as : e, and due !	stated. o the cause(s)					
	To t To t Com	Σ	29b. Signature and title of certifie	bereu	ml))	29c	License		74	18	29d. Date sig	ned (Month,	Day, Year)					
0	19		30. Name and address of person	lls Rd	6	alto	M	10	21	211									
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 0	2006 320 Regis	strar's Sign	nature	Me.												

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3 Time of Death Month Day Vear **Physician** Robert Rexroade 3 am 300% /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs If Under 5. Social Security Number 7. Age (In yrs. last birthday) Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F 213-36-0046 69 Director 04/03/1937 Maryland Usual Residence of Decedent . 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

9m 27 Is marked other then "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ratural", or items 23a or 28a-f sho amy Injury or other traumatic event, the Medical Examiner must be nettiled at once. 1 ☐ Yes 2 ☐ No Director MD Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 408 Rugby Ave 21225 USA by Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify. **Maryland 21215-002**(Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should 2 Thomas Rexroade Myrtle Canfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Step-brother 408 Rugby Ave., Baltimore, MD 21225 Ronald Kimery 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park, INC. 04/18/06 Elkridge, MD 4 Donation 5 ☐ Other (Specify) Cary L. Kaufman Funeral Home at Meadowridge Memorial Park, IV. 21. Signature of Funeral Service License 7250 Washington Blvd., Elkridge, MD 21075 M01378 Enter the disease, or confident that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 2005 Examiner Examiner O er signed by the attending physician and d be deteched for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 60 Physician/Medical to (or es Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tohacco use contribute to the cause of deeth? 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 🗆 No 1 ☐ Yes 2 No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturel
2 Accident 5 Pending investigation within 24 hours efter death.

To the Funeral Director: Aft
completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Hospital edical 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Yeer)

State Registrar

29b. Signature and title of certifier

26 31. Date filed (Month, Day, Year)

APR 2 0

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

2006

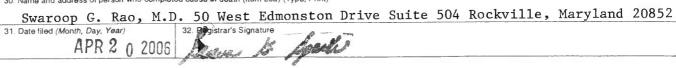
32. Segistrar's Signature

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Late 5 To 1 Live	of the other of the omple		and manner stated		29c. License numb	per	29	d. Date signe	d (Month, L	Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



completed cause of death (Item 23a) (Type, Print)

D35792

April 18, 2006

			1 - For State Registrar	State of Ma	aryland /		artment of <i>rtificate o</i>		Mental Hy	ygiene Reg. No.	U 6	1247
			1. Decedent's Name (First, Middle, La	st)	-				2. Date of D		V	3. Time of Death
	Physici /Medi		George	James		R	obinson		Month	18 2	Year 006	5: 30 AM
	Examir		4a. Facility Name (If not institution, giv	e street and number)				, or Location of De	ath	4c. Count		
			5104 Kramme Aven	ue			Brookly	'n		Anne	Arun	de1
	Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Yea	ar If Under 24 H		irth	9. Birthr	place (State or Foreign ntry)
П	Director		220-10-6904	(X M 2□ F	86	Yrs.	Months Day	s Hours Mi	62 2	26 1920	MD	ntry)
-	р. ,		Usual Residence of Decedent								-	
	thow	<u>.</u>	10a. State 10b. County		10c. City, To	own or Lo	cation				1	10d. Inside City Limits
	Pa-f	cto	MD Anne Ar	unde1	Broo	k1yn						1 ☐ Yes 2 No
	or 26	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show Linual be notified at		5104 Kramme Aven	ie .			21225	;		U.S.A.		
	r deg	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent o	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yes or N	o- 14. Ra	ce - Americ	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Itams 23a or 28a-f show event, tra Medical Exp. citier most be notified at	þ	1 ☐ Never Married 2 🎇 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	No		1□Yes 2XN		5.10 T 110411, 010.7	Specil	T T1	hite
9	72 ho	Completed	15. Decedent's E		10	6a. Dece	dent's Usual Occ	upation		16b. Kind of B	lusiness/In	dustry
2	hin .	ple	(Specify onfy highest gra Elementary/Secondary (0-12)	College (1-4or 5	(+)	life.	DO NOT use reti	ne during most of wired)	rorking			
2	filed wit Hygiene other the	PO	9	Conlege (1 40) C		Fina:	l Inspec	tion Off	icer	Корре	ers	
פ	e filed Il Hygid other vent, Il	Bec	17. Father's Name (First, Middle, Last,)				18. Mother's N	ame (First, Middle	e, Maiden Sumai	ne)	
<u>a</u>		Tof	Gordy Robinson					Myrtle	Wingate			
a			19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailir	ng Address (Stre	et and Number or			, State, Zip	Code)
			Mrs. Gladys Robin	nson/Wife		5104	Kramme	Avenue B	roolkyn.	MD 21225		
Baltimore,	s 1 and of Healt item 2 other		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of	()	Date	20c. Location		own, State
ê	Pages nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State			natory or other p	Apr	il 21,			
₫	artme ortan		21. Signature of Funeral Service Licer		Mead		idge Mem		006	Elkrid	e, MI)
e E	permit. Pages Depertment of H Important: If ite any injury or of		1 m Dalla	shall h	20136	4 1	Second	ress of Facility S Avenue S	W GLen B	urnie, M	. Home ID 210	e, P.A. 061
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lin	the death. D	o not ent	er the mode of d	ying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	A	c. Ji	MI	ande	al del	-a.t-		- 3	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequenc	ce of:	V Carrow	ac org	VCKCCCCOV]		-	
	Examiner		Opposed to the first over the con-		type	len-	Scori					
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a convenuence							
	cutec	Examin	Cause (Disease or injury that initiated events	C								
Ď	exe en ar rial-t		resulting in death) Last	Due to (or as a	a consequenc	ce of):						
08/PN	ificate be executed g physicien and as the burial-transit	edical	(d								
ĝ	tifica ig ph	ed										
XOD	w requires that the death certif been signed by the attending should be detached for use as	clan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d. Da	te of delive	ary
מ	deat e atte	Ca	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at			lEctopic pregnan Other (specify)	cy		Mo	onth	Day Year
j	oy the	Physi	9 □ Unknown	9□ Unknown								
ν, T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting	g in the ur	derlying cause g	given in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
	n sig								1 🗆	Yes 2 No	3 ☐ Prob	ably 4 Unknown
202	w rec	Completed							24a. Was	245	W/a-a- a4-	
ě	The law ate has b	립							auto	psy ormed2	prior to cor death?	psy lindings available mpletion of cause of
VItal	n: Ti ficate r, pa								1 ☐ Yes	26 No	1 🗌 Yes	2□ No
5	sicia certi recto	Be	25. Was case referred to medical examiner?	Hospital:				M	eath Check only			
ō	Phys this al di	. T	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier			3 DON	4 🗆 IVuising	Home 5 Res			()
	ding After fune	5	1∠Natural 5 Pending	(Month, Day	Year) 280	. Time of Injury	W		28d. Describe	how injury occur	red	
2	ttend death tor: the	cat	2 Accident investigation 3 □ Suicide 6 □ Could not be					Yes 2 No				
DIVISION	after after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	iry - At home, (Specify)	larm, stre	et, lactory, office	9	28f. Location (City or To	(Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospital or Attending Physician: The law within 24 bours after death, within 24 bours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	edical C	Check only 2 Medical Exan	ysician: To the best of	examination a	lge, death and/or inv	occurred at the	time, date and place	ce, and due to the	cause(s) and ma	anner as st	ated.
	thin 2 the mple	Med	,	and manner sta	1ed.							
	5 ¥ 5 0		29b. Signature and title of certifier	4 -	M.D)	29C. Licer	nse number	7	29d. Date signe		
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1/	_ `		30. Name and address of person who				11 -1	0	1	100 0		
0				URI, 8100		we	Huhw	ry, rasa	dena	MOZ	1122	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	rs Signature		3000					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#26, perMD 0854, 4/20/06 TT / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 06 04 Beverly Singleton-Hamlin 2006 Diane 4:34p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8820 Stonehaven Road Randallstown Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M X F 51 Yrs. 217-64-5107 05 22 MD Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits XX Yes 2□No Funeral Director MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 4805 Greencrest Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married 1 ☐ Yes 2√2 No Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Counselor Place Setters Inc. 12th grade 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ George R. Singleton Blanche Forest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Woodbourne Ave, Baltimore, Md Blanche Singleton-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/14/06 Loudon Park Baltimore, Md 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Amosari /dy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes No No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2000 Be 25. Was case referred to medical examiner? 26. Place of Death Check only one 20 No Hospital: Other: 4 Nursing Home 1 Tyes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Dea 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Ditatural
2 Accident iatural 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide +Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. been signed by the should be detached page 2 certificete or Attending Physician: director After thi death. within 24 hours efter deat To the Funerel Director: filled in by the Hospitel completely

Funeral

Director

"natural", or items 23a or 28a-f ehow Alcal Examiner must be notified at

7 is marked other then "nature traumatic event, the Medical

Important: If It eny Injury or o once.

Physician

Examiner

/Medical

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2 should be f and Mental I

Pages 1 and 2 s nent of Health an Item 27 i

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

333 31. Date filed (Month, Day, Year) 32 Registrar's Signature APR 2 0 2006

30. Name and addr ss of person who are pleted cause of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yeer **Physician** 4:30P M Ethe1 В. Smith April 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4 Marsham Court Baltimore Reisterstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Yrs. Director 90 216-03-3755 5, MD Feb. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 Marsham Court USA Funeral 21136 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MD Casualty Human Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be fi f Heelth and Mental H item 27 is marked ot John C. Smith Frances Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Department of Heelth ar Important; if item 27 Is any injury or other trau once. Wayne R. Krauch Nephew 313G Willrich Circle, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Druid Ridge Cemetery | 4/20/06 Pikesville, MD 21. Signature of Junyal Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physicien and s the burial-transit certificate be executed Box 68760, resulting in death) Last Due to (or as a consequence of): Physician/Medical attending if for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached o 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has al director, page 2 autopsy perform 2 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To the Hospital or Attending Phya within 24 hours after death.
To the Funeral Diractor: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 020649 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4902 BALTIMORE, MARYLAND CHARLES

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 2 0 2006

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Anna Mary Smith April 15 2006 11:25 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Laure1 Prince Georges Laurel Regional Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 🕮 F 213 20 5750 80 Oct. 17. 1925 Maryland Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State th and Mentel Hygiene. 27 is marked other then "naturel", or fleme 23a or 28a-f ehow traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Howard Laure1 Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9103 Lilac Park Drive 20723 U.S. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2월 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 T Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management Retail 12th 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mentel Hy Important: if item 27 is marked otheny injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) Be Harriet Siemont Andrew Holsey ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Douglas Smith / son 6204 Lawyers Hill Road Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Cedar Hill Cemetery 4/20/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature

✓ uneral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Onset and Death Immediate Cause (Final obstructive Lung Discome Chron 1c Physician pars disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo
9 Unknown Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 220 No page 2 this certificete Hospital or Attending Physicien: After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 Schlo 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Accident Injury 5 Pending To the Hospital or Attendis within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 (i) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 128998 ritamo 4-16-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Cherry

APR 2 0. 2006

31. Date filed (Month, Day, Year)

Saik

32 Registrar's Signature

Lane

			For State Registrar	State o	f Maryland	-	artment <i>rtificate</i>			ınd M	ental H	ygier Reg i	7111	U 6	12475
	- W		1. Decedent's Name (First, Middle,	Last)							2. Date of D	Death		V	3. Time of Death
	Physic /Medi		George Ernest Sa	atterfie:	Ld						ADRI		14	2006	2:4691
	Examir		4a. Facility Name (If not institution, g				4b. City, T	own, or	Location o	f Death			A	nty of Death	
	* _		BAHIMORE Washi	nation M			-		surr				ANI	DE AG	Taging
	Funeral		5. Social Security Number 6 212–18–9917	. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last	<i>birthday,</i> Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of E	Day, Yea		Cour	lace (State or Foreig try)
	Director		Usual Residence of Decedent		85						12-31	-192	20	MD_	
	yland		10a. State 10b. County		10c. City, T	own or L	ocation				-			1	0d. Inside City Limits
	s within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23a or 28a-f show The Modical Examinar must be notitled at	io	MD Anne A	runde1	Glen	Bur	nie								1 ☐ Yes 2ŒN
	th the	Director	10e. Street and Number				10f. Zip (Code				10g. (Citizen (of What Cour	ntry?
	23a (27 Chester Circ	le le			2	1060)				U.S	.A.	
	r dea	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S. erces?	13.	Was Decede	ent of Hi	spanic Orig	in? (Spe	cify Yes or h	10-		lace - Americ	
36	s afte	by Fu	1 Never Married 2 Married	If Yes, Giv	/0		1 ☐ Yes 2		Specify:		. ,		Spe		ite
21215-0036	hours lural'	d b	3 ⅓ Widowed 4 □ Divorced	Year or D		Gr. Dane	election (100 col	0				1			
5	n 72 n nat	Completed	15. Decedent's (Specify only highest of	rade completed)	'	(Give	dent's Usual kind of work DO NOT use	c done o	lurina most	of work!	ng	166.	Kind of	Business/Inc	dustry
12	within lene. than "	шс	Elementary/Secondary (0-12)	College (1	I-4or 5+)		chanic		,			F	3ow1	ing	
0	Hyg Hyg		17. Father's Name (First, Middle, La	st)		110	change		18. Mothe	r's Name	(First, Midd				
<u>a</u>	o a a	To Be	Leroy B. Satte	rfield					E13	sie S	S. Nea	rmar	1		
Maryland	shound N	-	19a. Informant's Name/Relationship		1	19b. Maili	ng Address	Street a						vn, State, Zip	Code)
	alth a		Mrs. Pat Hawkins	/ daugh	ter	27 (Cheste	r Ci	ircle:	G16	en Bur	nie.	. MD	21060	
J.	of Hez of Hez if item ir othe		20a. Method of Disposition		1 0000	e of Dispo	osition (Nam-	e of			ate			n - City or To	
Baltimore,	Pages nent of int: If it		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	-	n Ceme		· .	- 18-	-2006	Ма	rri	ottsvi	11e, MD
alti	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Lic	ensee	,	2	2. Name and	Addres					iner	al Hom	e, PA
m	30 5 5 8		Mark a.	Vancure	MO133									MD 210	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or oc shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on a	aused the death. [each line. (or as a consequence)	4				0.200		arrest,			Approximate Interval Between Onset and Death
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o as a consequen										. 1
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. 25	chevic	gan	que	N.	Since	U G	لمعننعلا				1 day
Ö,	e exection a		resulting in death) Last	Due to	or as a consequen	chof):								- 1	1 1
8760,	ate b hysic the b	dical		d											1 clay
.O. Box 6	ne death certif the attending thed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come of pregnancy inth 2 Fetal de- iant at time of death own	ath 3[□Ectopic pre □ Other (spe							Date of delive	ry Day Year
<u>а</u>	that the ned by detac	y Ph	Part II. Other significant conditions	contributing to de	eath but not resultin	g in the u	inderlying ca	use give	n in Part I.		23e. Dio	l tobacco	o use co	ontribute to th	e cause of death?
sp.	requires that een signed b hould be deta	d by	Cordiova	oulso-	discore						1	Yes	2 🗆 No	3 🗌 Prob	ably 4 Durknown
Vital Records,	> 0 2	Completed	Perophia	O Maso	when disc						24a. Wa	san	241	Were autor	osy findings available
Re	0 - 0	mc	1207 000	0.00							aut	opsy formed?		prior to cor death?	npletion of cause of
a	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical								1 Yes	2,21		1 🗆 Yes	2 No
		o B	examiner?	Hospital:	npatient 2 ER/	Outpatier/	nt 3 DOA	Othe			(Check only		A (7)		
ō		 	27. Manner of Death	28a. Date	of Injury 28	b. Time o		c. Injury Work	4 🗀 1101		8d Describe			ther (Specify	")
Division	C -5 =	ertification;	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	(Мол	th, Day Year)	Injury	м		? ′es 2□N						
<u> S</u>	Attender death	ifice	3 Suicide 6 Could not	289. Place	of Injury - At home	, farm, sti	reet, factory,	office		2				nber or Rura	Route Number,
ă	alor s afte	Cert	4 Homicide	buildi	ng, etc." (Specify)						City or T	own, Sta	ite)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical (29a. Certifier (Check only one) 1 Certifying 1 Medical Ex	aminer: On the ba	best of my knowled asis of examination ner stated.	dge, deat and/or in	h occurred a vestigation, i	t the tim n my op	e, date and inion, deat	place, a	nd due to the	e cause(e, date a	(s) and r	manner as st e, and due to	ated. the cause(s)
	To the within 2. To the complet	M	29b. Signatule and title of certifier				29c.	License	number			29d. D	ate sign	ned (Month, l	Day, Year)
	1			_ huss	w. um		D	CO S	1182	12		A	PAIL	142	Ja
,	1		30 Name no odre s if person wh		e of death (Item 23	a) (Type,	Print)			_			_		
1	1		LEREN MAIOL	(cm)	301 Ites	PITAL	DRIVE	5 (ilen	Bur	UIE,	WO	21	100	
383	Sta	ite	31 Date filed (Month, Day, Year)	32. R	egistrar's Signature	A TOPER	San San San San San San San San San San							1	

SATTER FELLO

			1 - For State Registrar	State	of Ma	ryland		artmen rtificat			and M		eg. Ño.	06	12476
di	Physici	an	1. Decedent's Name (First, Midd)	e, Last)								Date of Dea Month	th Day	Year	3. Time of Death
ĺ.	/Medic	_	Ruth		Н.		Smit	1				4 1	4	2006	11:45p м
	Examin	er	4a. Facility Name (If not institution	-		,				Location o			4c. C	County of Dea	ath
			Future Care		-			If Under		imore				NA	
4	Funeral Director		5. Social Security Number 215–14–4770	6. Sex 1 ☐ M 2 🏋 F	-	84	as <i>t birthday)</i> Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day 10 12	Year) 21	9. 8	rthplace (State or Foreign Va.
	and w		Usual Residence of Decedent 10a. State 10b. County		-	10c. City	, Town or Lo	cation				·			10d. Inside City Limits
	f ehc	ō	Md.	NA			Bal	timor	e						M☐Yes 2☐No
	the 28a-	rect	10e. Street and Number					10f. Zip	Code			1	Og. Citiza	en of What C	Country?
	3a or	by Funeral Director	1840 N. Rutlan	nd Avenue	2				212	213				ISA	,
	me 2	era	11. Marital Status	12. Was D	ecedent E	ver in U.S		Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No-	14		erican Indian,
9	after or Ite	Ē	1 Never Married 2 Mar		Forces?	lo					i, Puerto	Rican, etc.)		Black, Wh	
93	ours iral',	d by	3√ Widowed 4 □ Divorced	Year o	r Dates:			1 🗌 Yes	X	Specify:				Specify:	Black
21215-0036	be filed within 72 hours after death with the Maryland ital hygiene. id other than "natural", or Iteme 23a or 28a-1 ehow event, I've Medical Exert en must be notified at	Completed	15. Deceden (Specify only highe	t's Education st grade complete	ed)		16a. Deced (Give	kind of woi	rk done a	lurina most	t of worki	ng	16b. Kind	d of Busines	s/Industry
121	within ene. then	ш	Elementary/Secondary (0-12)	Colfeg	e (1-4or 5-	+)		DO NOT us)			177	RIES	
	filed v Hygie other i	ပိ	11th grade 17. Father's Name (First, Middle,	Last)		1	Lai	borer		18 Mothe	r's Name	(First, Middle,			
and	Mental I Merital I arked o	o Be		2301/	3/1	yfiel	1.4				ucen		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		low
Maryland	should be nd Menta marked imatic ev	L 2	Thomas 19a. Informant's Name/Relations	hip (Type, Print)	Ma	уттел		ng Address	(Street a			l Route Numbei	r. City or		
Ž	nd 2 lith a 27 is r treu		Barbara Boone	1	Viece		313	4 Rip	ple	Road,	Bal	timore,	Md.	21244	l ·
re,	f Hez f Hez ltem othe		20a. Method of Disposition	-		20b. Pta	ace of Dispo	sition (Nan	ne of	I		ate			r Town, State
Ë	Page nent c nt: If		N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal fro <i>pecify)</i>	om State		ruidri	,		1	9-20	-06	Bal	timore	e, Md.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other treumatic ex		21. Signature of Funeral Service	Licensee	2	•	22	. Name an	d Addres	s of Facilit	у	Bal	timo	re, Mo	1. 21202
<u>m</u>	8 9 E E 9		France	· At	ens	4	-	March	r.E	I. Eas	st	1101	E. N	orth A	Ave.
r			23a. Part1. Enter the disease, or shock, or heart faifure. List	complications the	at caused in each lin	the death.	. Do not ent	er the mod	e of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between
· ·	Physician		Immediate Cause (Final disease or condition	. Ai	hers.	Siles	otic G	isol	ovo	sula	2 d	isense			Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a	a consequ									
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	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury		to (or as-e	z censequ	erice or).								
	xecul and al-tra	хап	that initiated events resulting in death) Last	c	to (or as a	consequ	ence of):								
8760,	cate be executed physicien and the burial-transit	cal													
68	ificati g phy as the														
ŏ	death certific attending p	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,		of pregnan		Ectopic pr	0003001				23	d. Date of de	alivery
P.O. Box 6	deat	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pro		time of de		Other (sp						Month	Day Year
o. O	at the I by the	Phys	9 Unknown												
	res that the de signed by the a be detached f	þ	Part If. Other significant condition	~	1 ^	ut not resul	lting in the ur	nderlying ca	ause give	n in Part I.					to the cause of death?
O.	w require been sign	eted	H/o Serile	Meme	nua							-	es 2 🗆		robably 4 Nunknown
3ec	Attending Physician: The law requires that the death certificate be executed redeath. Act and the restriction has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed										24a. Was a autops perforr	V -	24b. Were a prior to death?	utopsy findings available completion of cause of
a	Physician: The lav this certificate has al director, page 2											1 ☐ Yes	2 1 No		s 2□No
Ę	sicia certi irecto	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	☐ fnpatier	at 0 🗆 E	R/Outpatien		Othe			(Check only on		CO: (0	
ō	Phy er this eral d	-	27. Manner of Death		te of Injur		28b. Time of		8c. Injury Work			ne 5 Reside			9CITY)
<u></u>	ttending death. ctor: Aft y the fun	at o	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	9	iontn, Day	Year)	Injury	м		?? /es 2 ☐ t	No				
Division of Vital Records,	or Attend efter death Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	100d 280, PT	ace of Inju	ry - At hor	me, farm, str	eet, factory	, office		2	28f. Location (St City or Town		Number or F	Tural Route Number,
	ital or irs efte ral Dir lled in											-			
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physician: To Examiner: On the and m	the best of abasis of anner sta	examination	vledge, death ion and/or inv	occurred vestigation,	at the tim in my op	e, date and pinion, deat	d place, a th occurre	and due to the ca	ause(s) a ate and p	nd manner a place, and du	s stated. e to the cause(s)
\	To t With To t	Σ	29b. Signature and title of certifie	Solya				29c	License	number 75	37	2	9d. Date	signed (Mon	th, Day, Year)
	1		30. Name and address of person	who completed c	ause of de	ath (ftem	23a) (Type,	Print)	NT	Roy	'A(AVE BI	167	MORE	th, Day, Year) -06 Z-1217
			31. Date filed (Month, Day, Year)		Peristra	r's Signati		. (00	,	-)	- c gans				
4	Sta Registr		A D D D	2006	Zelas	لكرين	· So	antil							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Bag. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 0208 AM Tillery 2006 Constance April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 VA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 212 F 76 Director 225-42-7687 04 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10b. County XXYes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 2542 West Coldspring Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 VNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 3√ Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 7th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Harris Howard Tillery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Coldspring Lane, Baltimore, Robert Tillery-Son 2542 West 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X\\ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify) Forest Lawn Memorial 4/23/06 Emporia, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 ele Baltimore, 4300 Wabash Ave, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Physician hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown ۵ sete has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 12 No 3 Probably 4 Unknown Completed ension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 1 No certificete Diabe To the Hospital or Attanding Physician: within 24 hours after death.

To the Funerel Director: Atter this certifice 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ■ ER/Outpatient 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Tes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) william B. Watson 201 E. Universit 0 Or 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

			riease	State of Mandand				-	•	<i>?</i> •
			1 State	State of Maryland				entai Hyg	giene	121.78
			1 - State Registrar		Cel	tificate of Dea			Reg. No.	16470
	Physici		1. Decedent's Name (First, Middle, Las Michael	9	-	Terrell		2. Date of Dea Month	Pay Soc	
	/Medi Examir		4a. Facility Name (If not institution, give	1		4b. City, Town, or Loca			4c. County of D	
			2020 Summ				Imore		107	Pinhalan /Chara - Farris
Ľ	Funeral Director		011/01000	x M 2□F 7. Age (III yrs. las	Yrs.		ours Min.	8. Date of Birti (Month, Day	, Year) 57	Birthplace (State or Foreign Country)
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, 7	Town or Lo	cation				10d. Inside City Limits
	Maryla	tor	MD NA		timo					XXYes 2□No
	or 28s	Direc	10e. Street and Number			10f. Zip Code			10g. Citizen of What	
	ath v s 23a	ral	2020 Summit Ave				207		U.S.	
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rigitlised at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	İ	Was Decedent of Hispan f Yes, specify Cuban, Me I □ Yes 2X No Sp		ify Yes or No- ican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc. Black
ð	2 ho	ted	15. Decedent's Ed	ucation	16a. Dece	lent's Usual Occupation			16b. Kind of Busine	
21215-0036	within 7 iene. than "n	Completed	(Specify only highest grade	College (1-4or 5+)		kind of work done during DO NOT use retired) Se Manage		g	Marylan of Corr	~
	tiled v Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	4710				(First, Middle,	Maiden Sumame)	
Maryland	buld be Mental arked o	To Be	James William 7	errell Sr		G1	oria R	MCC1	ullough	
ar y	2 shou and M Is mar sumat	-	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street and N				e, Zip Code)
	1 and 2 Health a tem 27 is		Fredrick Earle- 20a. Method of Disposition	-Friend 20b. Plac	2020 ce of Dispo	Sunnit 3 sition (Name of natory or other place)	ve Apt	H, Ba	ltimore, 20c. Location - City	Md 21207
Baltimore,	ages ant of l t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	netery, crer	natory or other place) morial Pa	rk 4/1	9/06		stown, Md
Ħ	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen					3,00	Randall	Scown, na
B	Department Department Impo		Shalle	K. Jones!	Ma 43	Name and Address of I rch F/H W OO Wabash	est Ave.	Baltin	more. Md	21215
	- 3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not ent	er the mode of dying, suc	ch as cardiac or	respiratory arr	rest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final	a. TROGICSIVE	M	116ford 1	p. 1600.	ownh	10/2001th	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequer	nce of):	arriver L	euroe	repri	aroparni	X MOINIS
S.	Examiner		Sequentially list conditions	b HIV/AI	I OS				7	
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequer	nce of):					
	be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c Due to (or as a consequer	nce of);					
760,	sician buria	calE			,					
	ficate physics the		`	d						
Вох	nding nding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc		-			23d. Date of	delivery
O. B	es that the death certificate be executed igned by the attending physician and be delached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □Fetal de 4 □ Pregnant at time of deat 9 □ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	hat the d by t letach	Phy	Part II. Other significant conditions co	entributing to death but not resulti	ing in the u	adertving cause given in	Dart I	23a Did to	hacca use contribute	a to the cause of death?
Records,	.= v =	ed by	- arrangement of the second se	Third and to down but not result						Probably 4 □Unknown
O O	aw requisible been 2 should	Completed						24a. Was a		autopsy findings available to completion of cause of
Ä	sician: The law certiticate has t rector, page 2 s	E O						autop: perfor	med? death	
Vital	ian: rrtitica ctor, p	BeC	25. Was case referred to medical examiner?			26.	Place of Death			
>	Physician: this certitic ral director,	70	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatien	t 3 DOA Other: 4	☐ Nursing Hom	e 5 V esid	ence 6 Other (S	pecify)
			27. Mann of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury				ow injury occurred	
Sio	Attending r death. sctor: After by the tune	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1 Tyes				
	or Att after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office	28	3f. Location (S City or Tow		Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to		29a. Certifier 1 Certifying Phy	ysician: To the best of my knowle iner: On the basis of examination	edge, death	occurred at the time, da	ate and place, an	nd due to the o	ause(s) and manner	as stated.
	the H iin 24 the F iplete	Medical	one)	and manner stated.	wirwol in	· · · · · · · · · · · · · · · · · · ·				
	To To	2	29b. Signature and title of certifier			29c. License num			29d. Date signed (Mi	/
7	/		Morrishe	1 Tuneth		D00	61015		7/14	12006
	5		30 Name and address of person who o	lete cause of death (Item 2:	(3a) (Type,	Print) D00 (11/2/1/2	<+	Br 14:	/2006 ore MD
		2	31. Date filed (Month, Day, Year)	32 Registrar's Signatur	n Again	COL N.	000176	- 0/	Dullim	016 1110
3	Sta Registi	-	APR 2 0 20		Jes John					

State of Maryland / Department of Health and Mental Hygiene 0 6

				Cei	tificate o	t Death		Reg. No.		
		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	_		me of Death
	Physician /Medical		Viola	Tennes	see		4	12 Day 2	2006 6:	13 a.m.
1	Examiner	4a Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Deal	h 4c. County	of Death	
-/-	Examiner	Future Care Cher	rrywood			Reister	rstown	Ba1t	:0	
	Funeval	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Yea		8. Date of Bi	rth	9. Birthplace (S Country)	State or Foreign
	Funeral Director	220-30-7442	□M 24 F	98 Yrs.	Months Day	s Hours Min.	8. Date of Bi (Month, Di 10-10	9. 1907	Country)	Va
		Usual Residence of Decedent								
	Puel Manual	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Ins	ide City Limits
	Mary Mary Or	Md Balte	,	Reisters	town				1 🗆	Yes XXNo
	188 the	10e. Street and Number			10f. Zip Code	9		10g. Citizen of V	What Country?	
	siter death with the Mar ritems 23s or 28s-fsin niner must be notified Funeral Director	12020 Reistersto	m Road							
	ath a 23				2113		Sacify Van or N	U S A	e - American Indi	an
	er de la la la la la la la la la la la la la	11. Marital Status	12. Was Decedent Ev Armed Forces?	91110,3.	f Yes, specify C	f Hispanic Origin? (S uban, Mexican, Puer	to Rican, etc.)	Blac	k, White, etc.	an,
20	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give		1⊡Yes 2XDN	lo Specify:		Specify	_e Black	
21215-0020	led within 72 hours e lygiene. har than "natural", o nt, the Medical Exan Completed by	3/LAvvidowed 4 □ Divorced	Year or Dates:					1 401 461 4 4 8		
5	"nat	15. Decedent's Ed (Specify only highest gra	ducation ide co <i>mpleted)</i>	16a. Deced	kind of work do	cupation ne during most of wo ired)	rking		Bryant	
12	A Parising	Elementary/Secondary (0-12)	College (1-4or 5+	2		nea)		Lane	Dryanc	
7	od vygie vygie C	6th grade		I/A Wr	apper	40 Mathada Na	(CiA & Aiddle	Maides Comes	-1	
n n	d oth	17. Father's Name (First, Middle, Last,				Alice Be		, Maiden Surnam	i <i>e)</i>	
<u>×</u>	Meni Meni Meni Meni Meni Meni Meni Meni	Henry Waddy				ATICE D	ells			
Maryland	s m s m	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stre	eet and Number or R				
	and alth	Grace R. Edwards	- Great Nie	ce 201	Inchca	pe Circle	#2 D	wings M	ills, Md	2111/
<u>e</u>	of He	20a. Method of Disposition		20b. Place of Dispo cemetery, crer	sition (Name of	place)	Date	20c. Location -	City or Town, Sta	ate
E	Pege ent c nt: If ry or	XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Arbutus			4-16-06	Arbutus	s, Md	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural" or Itema 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licer		22	. Name and Add	dress of Facility M	arch F/F	West		
Ba	Depa Depa Impo any Is	I made	A SAK	10011		4200 1	Tabaab A	Tromus D.	1+0 MJ	21215
		Novulle	U. YM	aut				venue Ba		
		3a. Pa 7. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line	ne peath. Do not ent	er the mode of c	aying, such as cardia	c or respiratory a	arrest,	Interv	ximate al Between and Death
	Physician	1-1-					_)	and boatin
-	nwedicar Examiner	Imprediate Cause (Final di ease or condition	, A	1 theima	er 15	Disease	2			
	_	esulting in death)		ue to (or as a consec						
7	i e		h						T- AT	
V	and trans	Sequentially list conditions,	D	ue to (or as a conseq	uence of):					
Ö,	ian e uriel-	rany, leading to immediate cause. Enter Underlying								
ox 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Di	ue to (or as a conseq	uence of):					
9	ng pl	, , , , , , , , , , , , , , , , , , , ,								
	endii endii r use	_	d							
ω.	The law requires that the deatt ate hes been signed by the atter, page 2 should be deteched for Completed by Physicia	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause	given in Part I.	23b. Did	tobacco use cor	ntribute to the ca	ause of death?
P.0	by the sech						1 🗆	Yes 2□ No	3 Probably	4 donknown
	ned e de									
Records,	n sig							an autopsy	24b. Were aut	opsy findings
8	v rec bee shor						pen	ormed?	completion of death?	n of cause
Re	e lav									0 T N =
a								Yes 2 WNo	1 ☐ Yes	∠∟ı №0
of Vital	Physicien: this certific ral director,	25. Was case referred to medical examiner?	Hospital:				ath (Check only			-
7	this cal dire	1 Yes 2 No	1 LJ Inpatient	2 ER/Outpatier	I 3LI DOA	4 Mursing I		idence 6 Oth		
_	ng P	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	V		28d. Describe	how injury occur	ea	
Sio	endi eath. or: A the fu	2 Accident investigation			M 1	☐ Yes 2☐ No				
Division	rect rect by	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, str <i>(Specify)</i>	eet, factory, offic	ce	28f. Location ((Street and Numb wn, State)	er or Rural Route	Number,
	tal o									
	To the Hospital or Attending Ph within 24 hours effer death. To the Funerel Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying Ph	ysician: To the best of niner: On the basis of e	my knowledge, death	occurred at the	time, date and place	e, and due to the	cause(s) and ma	nner as stated.	use(s)
	ha H in 24 he Fi plete	one) 2 Medical Exam	and manner state		- conganon, m (I)	, spinion, death occi				
	Vithi Vithi Com	29b. Signature and title of certifier	0 4			ense number	,	29d. Date signe		ear)
		1 Main 8.	palret.	, M.D.	12	Op 5 8 6 7	6	4-14	4-2006	
	1	30. Name and address of person who		ith (Item 23a) (Type.	Print)					
	9	Varen I Ral	114 M. D	7 = MA	in Str	cet, sui	te 200	> Reist	rrs pw	n, MD
	State	31. Date filed (Month, Day, Year) APR 2 0 200	\$2. Registrar	s Signature	18 D			c		21136
	Registrar	DDD 2 0 200	6 Marie	As Jagor						_
		HIII W O LOC	The state of the s							

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Mar		epartme Pertifica			Mental Hy	giene Reg. No.	06	124	80
	Physic /Medi	cal	Decedent's Name (First, Middle, Last) A. Facility Name (If not institution, give second content of th	Richard '	T. Taylo		. Taura		2. Date of D	15	Year 2006	3. Time of	
	Exami	ner	Mary and De 5. Social Sedurity Number 6. Sex	reral H	OSPITE I	Road If Und	er 1 Year	Location of Dea	S. 8 Date of Bi	rth	N/A 9. Birth	place (State o	or Foreign
	Director		Usual Residence of Decedent 10a. State 10b. County	//	72 Yrs				May 19	1933	Nor	th Car	olina
	death with the Maryland me 23e or 28e-f show fritts! be notified at	Director	Maryland N/A		Balti	more						10d. Inside Cit 1 XYes	-
	h with 23e or		345 South Stric	ker Street		101. 2	ip Code 21:	223		10g. Citizen		ntry?	
036		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	er in U.S.		edent of H ecify Cuba 2 🔯 No	ispanic Origin? (n, Mexican, Pue Specity:	Specify Yes or No rto Rican, etc.)		lace - Ameri lack, White, city: Whi	etc.	
2y ∫o€	ig e s	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5th	cation completed) College (1-4or 5+)		ecedent's Us ive kind of w e. DO NOT Owd Co		ation during most of we	orking	Oriol Camd			
RIChard Ta	2 should be filed withing and Mental Hygiene. Is marked other then aumatic event, the Menault aumatic event, the Menault aumatic event.	To Be Co	17. Father's Name (First, Middle, Last)	Taylor				18. Mother's Na	ame (First, Middle La Powel]	, Maiden Sum	ame)		
Mar	nd 2 should lih and Mer 27 is marke 27 is marke		19a. Informant's Name/Relationship (Ty) Genevieve Taylor					and Number or A icker St	Rural Route Numb	er, City or Tow lltimor			21221
Richard imore. Maryla	Pages 1 and 2 nent of Health int: If item 27 I		20a. Method of Disposition 1 Burial 2 Tornmation 3 R 4 Donation 5 Other (Specify)		20b. Place of Dicemetery, of Bayview	sposition (National Autory or	ame of other plac	e)	Date 8/2006	20c. Locatio	n - City or To		
Balti	permit. Pag Department important: R any injury o		21. Signature of Funeral Service License	namiscu	shi			s of Facility	Gonce Fu way Bal	neral S	Servic	e, P.A	
.8760.	Physician and ph	ai Examiner	23a. Part1. Enter the disease, or simplic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	0		g, such as cardia		rrest,		Approximate Interval Betw Onset and D	veen
. Box 6	death certific e attending p d for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic p 5 □ Other (s					ate of delive	,	ear
rds, P	w requires that s been signed b should be deta	by	Part II. Other significant conditions conf	inbuting to death but n	ot resulting in the	underlying	cause give	n in Part I.		obacco use co	ntribute to th		
Division of Vital Records, P.O	has b	Completed							24a. Was autor perfo 1 □ Yes	rmed?	. Were auto prior to cor death? 1 Yes	psy findings ampletion of car	vailable use of
r Vit	ysicia: is certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient	2 ER/Outpat	ient 3☐ D	OA Othe		ath <i>(Check only o</i> Home 5 ☐ Resid		thar (Chase	d.	
sion o	To the Hospitel or Attanding Physician: The within 24 hours after death. To the Funarel Director: After this certificate completely filled in by the funeral director, pa		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Ye	ear) 28b. Time	of y M	28c. Injury Work 1 🗆 Y		28d. Describe h			7	
Divi	pitel or At burs after of arel Direct filled in by		4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)				28f. Location (S City or Tox	m, State)			er,
	he Hos n 24 hc he Fun pletely	Medical	(Check only one)	cian: To the best of mer: On the basis of exa and manner stated.	amination andor	ath occurred investigation	at the time n, in my op	e, date and place inion, death occu	e, and due to the curred at the time,	cause(s) and n date and place	nanner as st , and due to	ated. the cause(s)	
•	To With	2	29b. Signature and title of certifier	200.		29	c. License	number 9566		29d. Date sign	ed (Month, L	Day, Year)	
-	5		30. Name and address of person who con	100 4	e Mar	e, Print)	1 Sei	val H	ospita')			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	me			•				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State	of Marylar		artment of I			ental Hy	/giene	11111	12481
			1. Decedent's Name (First, Mid	dle, Last)						2. Date of D	eath		3. Time of Death
	Physic /Medi		John Ross Vo	sburgh						Month April	Da 18.	2006	10:30P ^M
	Exami		4a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town, o	or Location of	of Death	pr.+-		. County of Deat	
	43		5617 Bradley				Betheso					Montgome	ery
	Funeral Director		5. Social Security Number 577-03-2703 Usual Residence of Decedent	6. Sex 1 ∑ M 2 ☐ F	7. Age (In yrs. 94	iast birthday) Yrs.	If Under 1 Year Months Days	Hours	24 Hrs. Min.	8. Date of Bi (Month, D Dec.	ay, Year)	9. Birt Co 1911 New	hplace (State or Foreign nuntry) York
	land ow		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	ith the Marylar or 28a-f show	ţ	Maryland Monts	gomery	Re	thesda							1 ☐ Yes 2 No
	r 288	Funeral Directo	10e. Street and Number	50		circoun	10f. Zip Code				10g. Cit	tizen of What Co	untry?
	23a o	a D	5617 Bradley I	Boulevard			20814				IIni	ted Stai	tos
	Items	ner	11. Marital Status		cedent Ever in U	l.S. 13.	Was Decedent of H		gin? (Spe	cify Yes or N		14. Race - Ame	rican Indian,
21215-0036	urs af	by	1 ☐ Never Married 2 💥 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 X Yes	2□No Wo:	rld r II	1 ☐ Yes 2 ☐ No		i, Puerto i	rican, etc.)		Black, White Specify:	e, etc. nite
5-0	n 72 hours "natural",	eted		nt's Education est grade completed	")	16a. Dece	dent's Usual Occup	ation	t of working		16b. K	(ind of Business/	
2	C * W	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done DO NOT use retire	d)	OI WOIKII	ig			
7	filed withi Hygiene. other than				+	Wri	ter/Edito					. Govern	nment
Maryland	A d a b	Be	17. Father's Name (First, Middle	, Last)				18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)	
3	should be nd Mental marked o	ို	John Vosburgh							Baker			
Mai	12 sho h and 7 is mu traum	1	19a. Informant's Name/Relation		2		ng Address (Street				-		
	s 1 and 3 f Health item 27 othar tr		Elvira P. Boni 20a. Method of Disposition	11a-Vosbu	rgh/Wife	5617	Bradley I	Boulev		Bethe			
آور	M O		1 Burial 2 ACremation			cemetery, creint gome:	natory or other pla-	CO)		L 21,	20c. Lo	ocation - City or	Town, State
Baltimore,	그 문문을 .		4 Donation 5 Other (Cre	ematori	um. Inc	I.	2006		Bet	thesda	Maryland
Bal	Department of the partment of		21. Signature **F neral Service	Licensee	10000	Be Be	?. Name and Addre ethesda-C	ss of Facility Chevy	y Kob Chas	ert A. e. Inc	. 75	phrey Fu 57 Wisco	neral Home/ onsin Avenue
32	A Same		23a. Part1. Enter the disease, of	or complications that	1. MOOSE	Do not out	ethesda,	Maryl	and	20814-	<u>-350</u>	1	
1			shock, or heart failure. Lis	t only one cause on	each line.	n. Do not ent	er the mode of dyir	ng, such as o	cardiac of	respiratory a	rrest,		Approximate Interval Between Onset and Peath
	Physician /Medical		disease or condition resulting in death)	a. Ce	MGES	tiva	MEes	tto	ail	4/2			months
	Examiner			Due to	(or as & conseq	uence of):	4 +	2					
4		<u>.</u>	Sequentially list conditions,	b. Due to	(or as a conseq	rence of):	(teri	12/81	esq				4 Ears
	nsit	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	(0) 43 4 0011304	201100 01/.							/
	be executed icien and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							
8760,	cate be executed oblysicien and the burial-transit												
68	ificate g phys as the	edlo		- U.									
Вох	death certifica e attending ph d for use as th	hysician/Medical	JF FEMALE: 23b. Was decedent pregnant		itcome of pregna							23d. Date of deli	verv
m	0 0 0	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 ☐ Feta nant at time of d		Ectopic pregnancy Other (specify)	′ 				Month	Day Year
0	at the de by the a	hys	9 Unknown	9□ Unkr	nown								
۵.	The law requires that the ole has been signed by the bage 2 should be detache	by P	Part II. Other significant condit	ons contributing to	leath but not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did t	obacco u	ise contribute to	the cause of death?
ğ	quire on sig uld b		Kinal 1	reikur	2					1 🗆 1	Yes 2	ØNo 3□Pro	bably 4 Unknown
ပ္ပ	law requii as been s 2 should	Completed								24a. Was	an	24b. Were aut	opsy findings available
Ä	The fav ete has page 2	E									rmed?	prior to death?	ompletion of cause of
ta	₩	a	25. Was case referred to medica	ıl .				26 Place	of Death	1 ☐ Yes Check only o	2 No	1 L Yes	2 🗆 No
>	Attending Physicien: r deeth. sctor: After this certilica by the funeral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Oth	OF:	sing Hom			6 □Other (Spec	(h/)
0	g Ph ler th leral		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time of	28c. Injur			8d. Describe			ny)
ō	eth. etc. Aff	atio	1 Natural 5 Pendi 2 Accident invest	ng (1910) igation	iii, Day 19ai)	Injury		k≀ Yes 2 🗌 N	10				
	or Atte	ertification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 289. Plac	e of Injury - At ho	me, farm, stre	eet, factory, office		21				ral Route Number,
۵	s afte	Cert	4 [] Florincide	build	ling, etc. (Specify	/)				City or To	vn, State,)	
	Hospitel 24 hours a Funerel I stely filled		29a. Certifier 1 ertifyi	ng Physician: To th	e best of my kno	wledge, death	occurred at the tin	ne, date and	place, ar	nd due to the	cause(s)	and manner as	stated.
	0 0	edical	(Check unly Z Medical one)	Examiner. On the t	pasis of examina iner stated.	tion and/or inv	estigation, in my o	pinion, death	h occurre	d at the time,	date and	place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certific	or, //			29c. Licensi	number			29d. Dat	e signed (Month,	. Day, Year)
)	7		Hama	m //en	nel , A	2.0.	D60	19			Anri	1 19, 2	006
17	+ 1		30. Name and address of person	16		-				į	1-1		- W
18	' /		Harris M. Ken					e, #92	25, 0	hevy C	hase	, Marv1	and 20815
	Sta	te	31. Date filed (Month, Day, Year,	32. F	Registrar's Signa								
* 4	Registr	ar	APR 2	0 2006	Seg. on a	M A	2060						
DHN	MH 17 Rev 1/20	001		Start.	A C. P. C. C. C. C. C.	The state of the s	W. C. C.						
						ORIGIN	IAL						

			1 - For State Registrar	(epartment of Health and Certificate of Death		Reg. No.	6 12482
	Physici	an	1. Decedent's Name (First, Middle, La Gordon Marion	,		2. Date of Dea	Day Y	3. Time of Death
1	/Medic		4a. Facility Name (If not institution, give		4b. City, Town, or Location of De		17 20 4c. County of	
	Examir	ıer		ton Medical Center	Glen Burnie	aun	Anne An	
	Funeral			Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 H			Birthplace (State or Foreign Country)
	Director		220-30-0378	1⊠M 2□F 71	s. Months Days Hours Mi	n. (Month, Day July 1	, 1934 N	faryland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	f eho	ō	Maryland Anne Aru	_				1 ☐ Yes 2 ☒ No
	28a	rect	10e. Street and Number	oren be	10f. Zip Code		10g. Citizen of Wha	at Country?
	h with	0	202 7th Ave., S.E	•	21061		United St	,
	deat	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		14. Race - /	American Indian,
98	or Ite	by Funeral Director	1 Never Married 2 Married	1 Yes 2 X No	1 ☐ Yes 2 ☒ No Specify:	ano rican, etc.)	Specify:	White, etc.
Ö	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f ehow 'n Madical Examinar must be notified at	d be	3 Widowed 4 Divorced	Year or Dates:				White
5	n na n na	plete	15. Decedent's E (Specify only highest gr	ade completed) (ecedent's Usual Occupation Give kind of work done during most of w ife. DO NOT use retired)	rorking	16b. Kind of Busin	ess/Industry
212	d with	Completed	Elementary/Secondary (0-12)	COMPAN (1-40r5±)	evision Technician		Electr	onics
Maryland 21215-0036	al Hyg	BeC	17. Father's Name (First, Middle, Last)	18. Mother's N	ame (First, Middle,	Maiden Sumame)	
<u>yla</u>	2 should be and Mental is marked o	2	George Marion War			Gazelle S		
Jar	and reum		19a. Informant's Name/Relationship (Mailing Address (Street and Number or I			
e,	1 and Heelth em 27 ther t		Shirley M. Ward /		2 7th Ave., S.E., (Glen Burn		
Baltimore,	Pages nent of I ant: If It		1 ⊠ Burial 2 ⊟ Cremation 3 [Removal from State cemetery,	crematory or other place) Ap:	ril 19,	20c. Location - City	
	_ + + + + -		4 □ Denation 5 □ Other (Special 21. Signature of Eurosal Service Lide					ie, Maryland
B	Depar Impor		1 Att all W		22. Name and Address of Facility Kirkley-Ruddick Fu 421 Crain Hwy., S	ineral Ho	me, P.A.	MD 21061
	1		23a. Part1. Eller the disease, ir com	plications that sused the death. Do no one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition	metentatic	colon cano	-		Onset and Death
	/Medical Examiner		resufting in death)	Due to (or as a consequence of)				Chickey
	LXammer	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b				
V	ted nsit	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)	:			
Ĭ	s be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a consequence of)				
68760,	ificate be executed physicien and as the burial-transit	edical	(d				
89	rtificate t	Medi	IF FEMALE:					
ROX	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death	3 Ectopic pregnancy		23d. Date of	,
	the all	sici	1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
Ţ.	that the sid by detac	F.		ontributing to death but not resulting in the	ne undertving cause given in Part f	23e Did to	hacco use contribut	te to the cause of death?
ďs,	uires that signed t id be det	d by	ilico s a e e e e e e e e e e e e e e e e e e e	and the second s	to diddinying cadso given in Fatti.	1 🗆 Y	1	Probably 4 Unknown
် လ	w requir been sl should	Completed				24a. Was a		
Ĕ	: The law cete has l page 2 s	E C				autops	sy prior deat	e autopsy findings available to completion of cause of h?
		BeC	25. Was case referred to medical		26 Pface of D	1 ☐ Yes eath (Check only of	3 No 1 1	Yes 2□ No
<u>></u>	nysicl lis cer direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2 ER/Outp	Other		ence 6 Other (Specify)
ם ה	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b. Tim (Month, Day Year) Inju	e of 28c. Injury at		ow injury occurred	
<u>0</u>	Attendii death. ctor: A y the fu	catlo	2 Accident investigation		M 1 Yes 2 No			
DIVISION	in b	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (S. City or Town	treet and Number o n, State)	r Rural Route Number,
	Hospitel or 24 hours after Funerel Directed in		29a. Certifier 1 Certifying Ph	VSician: To the heet of my keep land	Bath convered at the time of the size	 	(-)	
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	(Check only 2 Medical Exar	eysician: To the best of my knowledge, on the basis of examination and/of and manner stated.	r investigation, in my opinion, death occ	e, and due to the courred at the time, d	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	within To the comple	Me	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (M	onth. Day, Year)
			Asta	MO	D43977	E	Hail 1-	1 200/2
		+	30 Name and address of person who	completed cause of death (ftem 23a) (Ty	pe, Print)	•	- 1	550
	6		lingile Grenn	1. Il property	ewy Colon Burn	e mo	21061	
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	Scarles.			

		•	For State Registrar	State of Maryland	7 Departmer Certifica			R	eg. No:	The state of the s	12483
	Physici	an	Decedent's Name (First, Middle, Last)	11 -45				APr.L	Day	Year	3. Time of Death $9 \cdot 23A$ M
	/Medic Examin	al	4a. Facility Name (If not institution, give s	treet and number)	4b. City	r, Town, or Lo	ocation of Death	APr.L	4c. County	of Death	1.494
	Examin	let	Mary Cand Gener	1 1	tal F		more		Balti	more	City
	- Funeral		5. Social Security Number 6. Sex	M 2FTF	st birthday) If Unde Months		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year)	Cour	
	Director		218-46-8501 Usual Residence of Decedent	57	113.			Oct 26,	1948	Mary	Tand
	how		10a. State 10b. County	10c. City,	Town or Location					1	0d. Inside City Limits 1.☐ Yes 2 ☐ No
	Be-f-	Director	MD Baltimore	City Balt	imore	ip Code		1.	log. Citizen of V	Mhat Cau	
	with t	Dir	10e. Street and Number 911 West Lombard S	+		223			USA	viiat Codi	my:
	death	nera		2. Was Decedent Ever in U.S. Armed Forces?			anic Origin? (Spo Mexican, Puerto	ecify Yes or No-	14. Rac	e - Americ	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If itsm 27 is marked other then "natural", or Itams 23a or 28e-f ehow any fujury or other traumatic event, the Medical Examinar missible notified at once.	by Funeral	1 🔀 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1 🗆 Yes		Specify:	1110411, 010.7	1	, Bla	
20	72 ho	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Us (Give kind of w	ual Occupation	on ing most of work	ng	16b. Kind of Bu		dustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	"Housel	keeper			own ho	ne	
	il Hygi other	BeC	17. Father's Name (First, Middle, Last)			18	8. Mother's Name	(First, Middle,	Maiden Suman	тө)	
Maryland	Menta Menta arked atic ev	10 E	James King				Hattie 1				
Mar	12 sho n and 7 is m		19a. Informant's Name/Relationship (Ty) Jerome Williams	_	19b. Mailing Addres						
	1 and Health tsm 2		20a. Method of Disposition	Son 20b. Pla	2809 Gred ce of Disposition (Na netery, crematory or			Date	20c. Location -		
OE I	Pages ent of nt: If i		14 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	don Park (ry 04/2	2/06	Baltimo	ro Mo	ryland
Baltimore,	permit. I Depertm Importe eny Inju		21. Signature 1 Fundal Service Licens	•		and Address		27.000	DIAL LAND		Lyzniki
<u> </u>	89 E 2 8	123	23al Part. Enter the disease, or compli	**			Funeral			e MD	21229 Approximate
&:	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Metadatic Due to (or as a conseque	Lur		Cano				Interval Between Onset and Death
38760,	cate be executed physicien and sthe burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					·		
P.O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnance 1 Live birth 2 Fetal of 4 Pregnant at time of dea	leath 3 Ectopic					te of deliventh	ery Day Year
	Se 75 90	þ	Part II. Other significant conditions con	ntributing to death but not result	ting in the underlying	cause given	in Part I.			,	he cause of death?
of Vital Records,	e taw has b je 2 s	Completed						24a. Was a autop perfor	med?	Were auto prior to co death? 1 Yes	psy findings available impletion of cause of
ital	ician: Th certificate rector, pag	BeC	25. Was case relerred to medical examiner?			2	6. Place of Deat				X
× ×		၉	1 ☐ Yes 2 ☑ No		R/Outpatient 3 0			me 5 Resid			y)
uc	ding P. h. After funera	tion:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Oate of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury a Work? 1 ☐ Ye	s 2 No	28d. Describe h	ow injury occur	100	
Division	or Attandated after death Director:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, larm, street, facto			28f. Location (S City or Tow		er or Rur	al Route Number,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical C		sician: To the best of my know ner: On the basis of examination and manner stated.							
	To th To th comp	Me	29b. Signature and title of certifier		2	9c. License r	_		29d. Date signe	d (Month,	Day, Year)
			Mefen	(IMI)		1005	5008	· /	Apr. C	18	, 2006
	1		1/	Eawrence	00	27 1.	inden	Avenue	Baltin	loce	21201
34	Sta	ate	31. Date filed (Month, Day, Year)	32. Regitrar's Signatu				.,			
100	Regist	rar	APR 2 0	2006	M. August	2					

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Amend item 11 per inf 2854 4-25-06 art and Martal Hygians

			1 - For State Registrar	State of Ma	iyland		inment of Hi tificate of L		Mental H	ygiene. Reg. No	005	12484
	Physici	an	1. Decedent's Name (First, Middle, Last)	Miller	Wa	cker			2. Date of D Month	Day	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give s			CICI	4b. City, Town, or	Location of De	April	16	2006 County of Death	4:30 A. M
	Lxuiiii		341 Thelma Ave	enue			Glen Bu				Anne Ar	undel
	Funeral Director		100 24 7772	N 005	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		ay, Year)		place (State or Foreign ntry) nsylvania
	ow ow]	Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation					10d. Inside City Limits
	e Man la-f sh	ctor	PA. York		N	ew Cun	berland					1 ☐ Yes 2 🛣 No
	th with th	ai Director	10e. Street and Number 14 Terrace Place	ce			10f. Zip Code 170	70			on of What Cou	ntry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importent: if Item 27 is marked other than "natural", or items 23e or 28a-f show any figury or other traumatic event, the Madical Exercitus reliable motified at ODGE.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed + Deliverced	I2. Was Decedent E Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:		It	Vas Decedent of His Yes, specify Cubar ☐ Yes 2X No	spanic Origin? , Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)		1. Race - Ameri Black, White, Specify: Whi	etc.
2	"natu	etec	15. Decedent's Educ (Specify only highest grade			(Give	ent's Usual Occupa kind of work done de	urina most of w	orking	16b. Kind	d of Business/In	dustry
72	withir iene.	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5+	-)		oonoruse retired) k Driver			Т	rucking	
2	at Hyg	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maiden S	'umame)	
Z	d Ment marked matic	2	John H.			4.00			ssie Hake			
S	nd 2 sl lith and 27 is r		19a. Informant's Name/Relationship (Type Bernece J. Wacker	. ,			g Address <i>(Street al</i> errace P1		lew Cumbe			
Baltimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro		20b. Pla	ice of Dispos	sition (Name of patory or other place		Date		ation - City or To	
Ě	t. Pag tment tent: i		4 □Donation 5 □ Other (Specify)		Ro1		Green Cem.		0/2006		Hill,	
Ba	Depermine Depermine Important irrespondent i		21. Signatule of Juneral Service License	Mo122	20	1	Name and Address 001 Ritch:		Gonce Fu way Bal			e, P.A. land 21225
	Physician		23a. Part1. Star the disease, or complice shock, or heart failure. ist only on Immediate Cause (Final disease or condition	A		Do not ente			ac or respiratory	-		Approximate Interval Between Onset and Death Month
	/Medical Examiner		resulting in death)	Due to (or as a				10 -	7111 001			
	sit set	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):						
a î	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):						
8/60,	icate be executed physicien and s the burial-transit	dical	C ₀									
O. Box 6	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal	death 3 □	Ectopic pregnancy Other (specify)			230	d. Date of delive Month	ery Day Year
-	law requires that the de es been signed by the a 2 should be detached f	۵	Part II. Other significant conditions conf	tributing to death but	not result	ting in the un	derlying cause giver	n in Part I.		tobacco use		ne cause of death?
Hecords,	0 - 0	Completed								psy ormed?	prior to co death?	psy findings available mpletion of cause of
VITall	ician: Th certificete rector, pag	BeC	25. Was case reterred to medical examiner?						1 ☐ Yes eath (Check only	one)	1 🗆 Yes	2L NO
=	sic dis	2	1 Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury		R/Outpatient	3 □ DOA Other	4 Nursing	Home 5 Res			1500's Home
<u></u>	nding f ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	Work?	es 2 □No	28d. Describe	now injury c	occurred	
Division	al or Atte after dea Directo d in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At hom (Specify)	ne, tarm, stre	et, factory, office			(Street and I wn, State)	Number or Rura	l Route Number,
	To the Hospitel or Attending Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funeral	Medical C	29a. Certifier (Check only one) Certifying Physical Certification Certification Physic	and manner state	ixaminatio	n and/or invi	stigation, in my opii	nion, death occ	curred at the time,	date and pl	lace, and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	/ ,,,			29c. License	number		29d. Date s	signed (Month,	Day, Year)
ł			/ CW Ca	LND			1) 16	354		4/17	1/200	06
1:	27			npleted cause of dea	th (Item 2	23a) (Type, F	CATON.	AVE .	BALTIM	ORE	MD.	Day, Year) DE 21229
3.	Sta Registra		31. Date tiled (Month, Day, Year) APR 2 0 2006	32. Registrar	s Signatu	re .						·

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM/19a PER FH G856 6/2/06 WS
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland		irtment of He tificate of D			iene 200	6	12485
	Physici /Medic		1. Decedent's Name (First, Middle, Last) FERALDINE	NEXANDER				2. Date of Deat Month APRIL	Day	Year 6	3. Time of Death D727 AM
	Examin		4a. Facility Name (If not institution, give st MONTGOMEN) GE	reet and number) NERAL HOSPITA	12	4b. City, Town, or DLNE			4c. County		ERY
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. las M 2 🛛 F		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 1 19	Year)	9. Birthp Cour Tenne	
	B Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Geo	rge Laure							0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	as or 28	I Director	10e. Street and Number 7901 Laurel Lake Court,	Apt 406		10f. Zip Code 20707			0g. Citizen of 1	What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Example Times the Licities of an ance.	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar t ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:		14. Rad Bla	ce - Americ ck, White, y: Blac	
21215-0036	I within 72 houiene. I then "nature The Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	Completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired, anager	ition luring most of work)	ang	16b. Kind of B		·
pug	be filed ntal Hygie od other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	•	Maiden Sumar	ne)	
Maryland	2 should and Mer is marks aumatic	오	Frank Howard 19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	ng Address (Street a	011ie Sile and Number or Ru		, City or Town	, State, Zip	Code)
altimore, N	Pages 1 and nent of Health sut: If item 27 ary or other tr		Thomas Alexander, Fath 20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	20b. Plac cent	e of Disponetery, crer	Laurel Lake sition (Name of natory or other place tional Ceme	e)	Date	20c. Location		
Balti	permit. Departri Imports any inju		21. Signature of Funeral Service License	Sales	22	2. Name and Addres 7601 Sar	ss of Facility Findy Spring			yland	20707
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compliants shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If ally, leading to unmediate cause. Enter Underlying Cause (Disease or injury that initiated events	e cause on each line.	ard	er the mode of dying		or respiratory arr	est,		Approximate Interval Between Onset and Death WEE
8760,	ficate be executed physicien and is the burial-transit	dical Exar	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
P.O. Box 6	Hospital or Attending Physician: The law requires that the death certific thours after death. Funeral Director: After this certificete has been signed by the attending Ferneral Director: After this certificete has been signed by the attending felly filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3[Ectopic pregnancy Other (specify)				ate of deliv	ery Day Year
ds, P.	uires that signed by Id be deta	þ	Part II. Other significant conditions con	tributing to death but not result	-		en in Part I.	23e. Did to		atribute to	the cause of death? bably 4 DUnknown
Division of Vital Records,	The law require ete has been sig page 2 should b	Completed	ANTIPE	tos PHOLIPIDS	YN DR	DME		24a. Was a autop perfor	sy med?	Were aut prior to death? 1 Yes	opsy findings available ompletion of cause of
of Vita	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes		R/Outpatier		er: 4 🗆 Nursing H	th Check only or ome 5 Resid	ence 6 □Ot		rfy)
ision	ittending f death. ctor: After / the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year) 28e. Place of Injury - At hom	Injury	M 1	k? Yes 2 □ No	28f. Location (S	itreet and Num		al Route Number,
<u>S</u>	pital or A		4 ☐ Homicide determined 29a. Certifier 1⊠ Certifying Phys	building, etc. (Specify)			ne date and place	City or Tow	n, State)		
	To the Hos within 24 hd To the Fun completely	ledical	(Check only 2 Medical Exami	ner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death occu	rred at the time, o	date and place	, and due	to the cause(s)
)	To Too	Σ	29b. Signature and title of certifier	thesperaus	T	29c. Licens	62656		29d. Date sign APKL		
	4		30. Name and address of person who co	impleted cause of death (Item :	23a) (Type, E PH1	Print) LLP DRIVE	F, DLNE	Y, MARY	MUD.	2083	2
San Collection	St Regist	ate rar	SONA HOLMES M-1 31. Date filed (Month, Day, Year) APR 2 1 2	32. Registrar's Signatu	19	series		,			

			i icase i	State of Maryland /	Department of Health	and Mental Hyg	iene	
		•	For State Registrar	otato or marytana.	Certificate of Deat	44.	eg. No.2 0 0 6	12485
			Decedent's Name (First, Middle, Last,			2. Date of Deal	th Day Year	3. Time of Death
,	Physicia /Medic	_	ISABELLE	L. ALLEN		April	19 2006	92 -
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location		4c. County of Death	
			5. Social Security Number 6. Se	14-4.		der 24 Hrs. 8. Date of Birth	CITY 9. Birthp	lace (State or Foreign
	Funeral Director		217-20-1948	IM 2×F 78	Yrs. Months Days Hour	der 24 Hrs. 8. Date of Birth (Month, Day)	1927 MA	lace (State or Foreign try)
			Usual Residence of Decedent					
	anylan	_	10a. State 10b. County	10c. City, 10	own or Location	7.1.07= N		0d. Inside City Limits 1 X Yes 2 □ No
	with the Maryland a or 28a-f ehow	ecto	MARYLMUD N 10e, Sireet and Number	/A	10f, Zip Code	TIHORE CI	0g. Oftizen of What Coun	ntry?
	with with Live	급	517 N. P.	I NEVI STRI	GET -7	1223	USA.	,
	me 23a	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No-	14. Race - Americ Black, White,	an Indian,
٥	ours after death with the Maryla elf, or Iteme 23a or 28a-f e hou Examinat must be notified at		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give	1 ☐ Yes 2 ☒ No Spec		Specify:	- 1d
200	72 hours "naturel", idical Exe	d by	3 Widowed 4 □ Divorced	Year or Dates:	6a. Decedent's Usual Occupation		16b. Kind of Business/Ind	ACK
۲ ک	n 72 i	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give kind of work done during n life. DO NOT use retired)	nost of working	TOD. KING OF DUSTINGS STATE	dustry
717	with jene. r ther	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSEKE	EPER	PRIVATE	FAMILIES
2	e filec al Hyg l othe vent,	Be C	17. Father's Name (First, Middle, Last)			other's Name (First, Middle,		
<u>X</u>	Ments Ments arked arice	2	NATHANIEL			SABELLA		WYER
<u>la</u>	12 short and riem		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing Address (Street and Nut			ラノフフ <i>ラ</i>
<u>က်</u>	thealt		VANESSA ALLE 20a. Method of Disposition	20b. Place	5/7 N. PULASE e of Disposition (Name of	Date	71 HORE, MD 20c. Location - City or To	own, Slate
ē	ages ent of nt: if if		1 Burial 2 Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	etery, crematory or other place) 3- MEM PARK	04-22-06	WOODLAWI	N. MARUIANA
	mit. F partm portar / injur		21. Signature of Funeral Service Ligens			acility BROWN		AL HOME
ñ	P P P P P) Carti		2740 N. FG	ILTON AVE. C	ALTIMORE, I	MD. 21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death. (ne cause on each line.	Do not enter the mode of dying, such	n as cardiac or respiratóry ari	est,	Approximate Interval Between Onset and Death
y. 1	Physician		Immediate Cause (Final disease or condition resulting in death)	a RESPIRATE				days
	/Medical Examiner		Tesaking in doubly	Due lo (or as a consequen	DKSTRUCTUS	PULMONIRY	DI CEN E	402-1
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	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c				
Ö,	e be executed sicien and s burial-transit		resulting in death) Last	Due to (or as a consequen	ice of):			
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× 68	eath certificat ettending phy I for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy	,		23d. Date of delive	erv
Box	etten etten I for u	clan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No	1 Live birth 2 Fetal de 4 Pregnant at time of deatl	ath 3 Ectopic pregnancy		Month	Day Year
o.	t the d	hysi	9 Unknown	9□ Unknown				
o,	res that the de signed by the e i be detached i	by P	Part II. Other significant conditions co				bacco use contribute lo ti	
ğ	w require been signal	ted	- HYPERTER SIAN		som insuffice		'es 2∙⊠No 3 Prob	bably 4 □Unknown
Records,	The law requires that the death certifica ete has been signed by the ettending ph page 2 should be detached for use as it	Completed by Physiclan/Med	5/P CV1. 5/P	1 - 6	ABOOMINM RIR	autop	an 24b. Were auto prior to co death?	opsy findings available empletion of cause of
	hysician: The law his certificete has E il director, page 2 s			morrow. Cal	DECUSFECTOMY .	> > TI CHAMIN 1 □ Yes	Z□ No 1 □ Yes	2□ No
Vital	sician certif recto	Be c	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{Mo} \)	Hospital: 1 ☐ Impatient 2 ☐ ER	Other	Place of Death (Check only o		ful .
ŏ	Phys er this eral di	n: To	27. Manner of Death		3b. Time of 28c. Injury at		ow injury occurred	.,,
Division of	Attending Physician: r deeth. sctor: After this certifice by the funeral director, I	Certification;	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation		Injury Work? M 1 ☐ Yes 2	2 □No		
Σis	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Al home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (S City or Tow	Street and Number or Rura vn, State)	al Route Number,
	To the Hospital or Attending Pr within 24 hours after deeth. To the Funersi Director: Attent completely filled in by the funeral		20 0 15 1 1 1 1 2 1 1 1 2 1 1 1 2 1 1 1 1 2 1 1 1 1 1 2 1	To be be a few to the state of		and place and due to the		rtated
	Hosp 24 ho Fund Fund stely fi	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	iner: On the basis of examination and manner stated.	edge, death occurred at the time, dat n and/or investigation, in my opinion,	death occurred at the time,	date and place, and due to	to the cause(s)
	vithin o the	Me	29b. Signature and title of certifier		29c. License numb		29d. Date signed (Month,	-
	0) fel	year MI	D19	017	April 16	9 2006
i	1		30. Name and address of person who		3a) (Type, Print)	Bon seu		00,000
_	<u>y</u>		TELAYO Y.	Co A CEI		1901	JUVE 140	PHIM
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	Soules			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland		artmen tificate			nd Menta	i Hygie	2.000	12487
ov.	Physic	ion	1. Decedent's Name (First, Middle, Last)						2. Date	e of Death	Day Year	3. Time of Death
	/Medi		Emmett Howard Alle							Apr		9, 2006	8:00 A. M
	Exami	ner							4c. County of De	ath			
			6102 Maylane Drive 5. Social Security Number 6. Sec		ge (In yrs. las	ct hirthda	If Under	alti	MOYE If Under 24	Hrs la Day	of Disth		N/A
	Funeral Director		- 1	M 2□F	85	Yrs.	Months	Days		Min. (Mo	of Birth nth, Day, Ye il 30	,1920 Ba	nthplace (State or Foreign Country) 1timore, MD.
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show alsel Examiner shall be millined at		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Man.	tor	Maryland N/A		Bal	timor	A						Mo 2 □ No
	or 28	Funeral Director	10e. Street and Number			921102	10f. Zip	Code			10g.	Citizen of What C	Country?
	23a	la	6102 Maylane Drive)				21	212			United S	States
	tems	une		 Was Decedent Amed Forces 	?	13. V	Vas Deced Yes, spec	ent of His	panic Origin , Mexican, F	? (Specify Ye: Puerto Rican, e	s or No-	14. Race - Am Black, Wh	encan Indian,
36	s afte	by F	1 Never Married 25 Married 3 Widowed 4 Divorced	1. Yes 2 ☐ If Yes, Give	No		☐ Yes 2		Specify:			Connié u	√hite
8	hour	edt	15. Decedent's Edu	Year or Dates:		16a. Deced	lent's Hsua	I Occupat	ion		166	o. Kind of Busines	
115	nin 72 n "ne	plet	(Specify only highest grad	e completed)		(Give	kind of wor OO NOT us	k done du	iring most of	working	100	o. Kind of Busines:	s/maustry
21215-0036	filed within Hygiene. other than "ent, It a Mex	Completed	Elementary/Secondary (0-12)	College (1-4or	3+)	Mac	hinis	+			Tate	estinaho	100
P	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Madical Examiner mark by intilling at	Be	17. Father's Name (First, Middle, Last)	11, 0		2 11.403	- 		18. Mother's	Name (First,			156
<u>la</u>	2 should be and Mental is marked of aumatic eve	10E	E.H.Allen					1	A.C.Sl	.ater			
Maryland	2 sho and is mu		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address	(Street ar	nd Number o	or Rural Route	Number, Ci	ity or Town, State,	Zip Code)
	1 and Health em 27		Mrs. Gloria K. All	en(wife)		6102 I				Balti		Maryland	21212
altimore,	90= 5		20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ R	emoval from State		ce of Dispos ne <i>tery</i> , c <i>rem</i>				~1 20,		Location - City o	
ţ	Department mportant: Pag	1 4	4 ☐ Donation 5 ☐ Other (Specify)		Evan	s Fune				2006	E	Forest Hi	ll, Maryland
Bal	Departm Departm Imports ony inju		21. Signature of Funeral Service Licens	yair	, Dr	23	Name and acefu 25 Yo	I Ali	ternat bad	iyes Fi Timoni	uneral um, Ma	l&Cremati aryland	on Ctr.,P.A. 21093
			23a. Parti. Enter the disease, or compli spack, or heart failure. List only or	cations that cause le cause on each li	d the death. ine.	Do not ente	er the mode	of dying,	such as car	rdiac or respira	atory arrest,		Approximate Interval Between
Algori	Physician		Immediate Cause (Final disease or condition	METASS Due to (or as	1 xtcc	mal	IGN AN	Cu					MONTM
	/Medical Examiner		resulting in death)			nce of):	7						
19		_	Sequentially list conditions,	DUNKNO		PRIN	LAVY						
	ted	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
,	al-tra	xai	that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):							
8760	death certificate be executed e attending physician and od for use as the burial-transit												
9	tificat ig phy as th	led	-22,	•									
Вох	ih certifici ending pl	N/UE	230. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth			Ectopic pre					23d. Date of de	livery
	e death	Physician/Medical	in the past 12 months?	4 Pregnant a			Other (spe	ecity)				Month	Day Year
P.0	that the de ned by the a detached	Phy	9 Unknown										
of Vital Records,	w requires that lhe been signed by th should be detache	þ	Type Z DIABETES		out not resultii	ng in the un	derlying ca	iuse given	in Part I.	23e	. Did tobacc	V	o the cause of death?
oc o	aw Is b	Completed	ChroNE YENAL 1.	o suffic	1 CNC9					24a	. Was an	24b. Were a	utopsy findings available
<u> </u>	The ate h page	Com	HYDEATENSION	* /						10	autopsy performed Yes 2	2 death?	completion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			00020:			26. Place of	Death Check			
£	S S 5	2	1 103 24 100	ospital: 1 🔲 Inpatie		VOutpatient			4 🛄 Nursir			6 ☐Other (Spe	ecify)
n	Jing F J. After funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury		c. Injury a Work?		28d. Des	cribe how in	njury occurred	
isi	Attending r death.	cat	2 Accident investigation 3 Suicide 6 Could not be	One Diseased in	^^ >	- 41	М		s 2 No	004	.: (2)		
Division	after deatl after deatl Director: d in by the	Certification:	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	e, rarm, stre	et, ractory,	опісе		City	or Town, St	and Number or R ate)	ural Route Number,
	To the Hospital or Attending Phywithin 24 hours alter death within 12 to the Funeral Director. After toompletely filled in by the funeral	dical C	29a. Certifier (Check only one)	ician: To the best er: On the basis o and manner sta	r examination	n and/or inve	estigation,	in my opir	nion, death c	occurred at the	time, date	and place, and du	s stated. s to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	3			29c.	License r	number	o od o	29d. l	Date signed (Moni	h, Day, Year)
	/	,	> 1/Dand 1011	t. MA				71	715	0		4/20/00	
-			30. Mame and address of person who co	ppleted cause of d	leath (Item 23	За) (Туде, Р	Print)	4	1 ()			11-100	0
1	141		Koland W	eta		Lut.	ten	ell	e m	nd o	2109	3	
8.5	Sta		31. Date filed (Month, Day, Year)	32. Regian	ar's Signature	8	Rock	10	7				
*	Registr	ar	APR 2 1	2006	BLASE .	No A	1000						

DHMH 17 Rev 1/2001

LaTonya Shenelle Barrentine

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	or waryland /		icate of D		id ivicina	, ,	eg. No. 2	00	6 1010	
Physic		1. Decedent's Name (First, Middle,Las	et)				-	2. Date of Dea	th	ar ar	3. Time of Death	
Medical Exam	ııner	LaTonya Shene1 4a. Facility Name (if not institution, given	<u>le Barrer</u>	ntine	- Ah	Oite Taura	al anation of Da	Month April 14, 2			2359 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location or Southern Maryland Hospital							4c. County Prince (s	
Funera		Social Security Number 6. S.		(In yrs. last l		f Under 1 Yea	ar If Under 24	Irs. 8. Date of Bir	th(MM/DD/YYY			
Directo		251-49-8382	M 2 XF 2	26	Yrs.	Months Day		1in.	, 1979	Foreign		
		Usual Residence of Decedent	2 251 2					Aug. /	, 1979	300	en Carollia	
, any		10a. State 10b. County	10	Oc. City, Tov	vn or Location						10d Inside City Limits	
Aaryland 28a-f show Lat once.	6	Maryland Prince	George's	Brand	lywine						1 Yes 2 X No	
Maryl - 28a-	rector	10e. Street and Number			10	Of. Zip Code		1	0g Citizen of W	hat Count	ry?	
th the Maryland 23a or 28a-f she notified at once	<u>=</u>	8304 Sunnybrook C	ourt			20613			U.S.A.			
21215-0036 Mental Hygiene Mental Hygiene Mental Hygiene, Sampled other than "natural", or items 23a or 28a-f she overt, the Medical Examiner musts be notified at once overt, the Medical Examiner musts be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ex Armed Forces?		13. Was Di If Yes,	ecedent of Hi specify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Race Whit	e - Americ e, etc.	an Indian, Black,	
ter de ", or i			1 Yes 2 X	No	1 ☐ Ye	s 2X No	specify:		Specify	B1ac	k	
ours af ntural	d by	15. Decedent's Education (Specify o	or Dates:	leted) 16	a. Decedent's l	Jsual Occupa	ation (Give kind o	of work done	16b. Kind of Bu			
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		-	e. DO NOT use r	etired)				
Nedi	Ĕ		2		Mana	ager			Dollar		eral	
15-00 filed will Hygier ed other		17. Father's Name (First, Middle, Last William Lee Barr						me (First, Middle, M		9)		
2121 uld be fi Mental marked	To Be	19a. Informant's Name/Relationship (7	and the same of th		19b. Mailing Ad	Idress (Stre		n Manning or Rural Route Num		n State	Zin Code)	
and 2 shot lealth and tem 27 is 1	-	Littin M Barrent	ine (Mother					C George			' '	
e, North Teach Treated Tricem		20a. Method of Disposition			e of Disposition		emetery,	Date	20c. Location	- City or T	own, State	
Baltimore, MD 21215-0036 semir Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene program: If item 27 is marked other than njury or other traumatic event, the Medica		1 X Burial 2 Cremation 3 4 Donation 5 Other Specify	_	' I	ing Glo		4,	/20/06	George	town	, sc	
Baltimo permit Page Department of Important: injury or off		21. Ignature of Funeral Service treensee 22. Name and Address of Facility Wilds Funeral Home										
		Dennes Vel	Imeur		130) Merr:	<u>iman Rd.</u>	., George			440	
Physician /Medica		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and										
xamine		Immediate Cause (Final disease or condition resulting in death) a OCClusive Pulmonary Thromboemboli Due to (or as a consequence of):										
			Deep Venous Thr	,								
	ner	if any, leading to immediate	Due to (or as a consequ									
	aminer	(Disease or injury that initiated C.	Right Ankle Injury Due to (or as a consequ									
cuted nd transit	Ä	d.										
760, icate be executed physician and the burial - transit	/Medical	UNPENDED	AMENDED									
760, ficate be physici	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnand					23d Date of			
Box 68 c death certif the attending ed for use as	ciar	past 12 months?	1 Live birth 4 Pregnant at tin	ne of death	2 Fetal of	death 3 (Specify)	Ectopic preg	nancy	Month	Da	y Year	
Boy death the att	Physiciar	1 Yes 2 No 9 V Unknown	9 Unknown		o Other	(Opcony)					i	
that the d ned by the	by P	Part II. Other significant conditions	contributing to death b	ut not result	ting in the unde	rlying cause	given in Part I.				e cause of death?	
S, P uires t n sign Id be c								-			bly 4 V Unknown	
ords, w requir as been s	Completed					 .		24a, Was a autop:	sy f	orior to co	psy findings available mpletion of cause of	
Rec The la icate h	E							perfor		death?	2 No	
Vital Revysician: The this certificate director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Innetices		_		e of Death (Chec					
f Vi Physi er this	1 -1	1 V Yes 2 No 27. Manner of Death	28a. Date of Injury		Outpatient 3 Time of Injury		Other Nurs		Residence 6	Other		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death and Director. After this certificate has been signed by the funeral director, page 2 should be detacted.	Certification:	1 Natural 5 Pending	FOUND:	r) FC	DUND:		Yes 2 ✓ No		now injury occurr auto collision			
isical in Particular Arter dea	icat	2 Accident Investigati	28e Place of Injur		58 hrs farm, street, fa			28f. Location (S	treet and Numb	er or Rura	I Route Number, City	
Divi	erti	3 Suicide 6 Could not determined	De l			,	J	or Town, St	tate)		Prince George's	
D Hospital 24 hours Funeral		On Codding	an: To the best of my k		death occurred	at the time, d	ate and place, a					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Functal Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transi	Medical	one) 2 Medical Examiner										
/	Σ	29b. Signature and title of certifier	1.0			29c. Licens			29d Date sign		h, Day, Year)	
1		Caral Ha	llan	_		O.C.	M.E.		April 15, 20	006		
6		30 Name and address of person who Carol Allan, MD Assista	completed cause of dea		•	of Dallie	oro MD 040	201				
V)	tate		32. Registrar's		r Felli Sife	eci, DaliiM	ore, MD 212	.01				
Regis		31 Date filed (Month, Day, Year) APR 2 1 20	106 Figure	13	A STATE OF							

	·	For State Registrar		State of Ma	iryland		tificate of L			Reg. No.	006	124	89
Physici /Medi		1. Decedent's Nam Corine	e (First, Middle, La:	st)			Brow	n_	2. Date of De Month April	Day	2006 Year	3. Time of 4:30	A ^M
Examir			of not institution, given the stleton Di	e street and number)			4b. City, Town, or Upper M	Location of Death arlboro			County of Deal	h George'	s
Funeral Director		5. Social Security N	-3335	C TT -	6 (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	th Year)	9. Bin	thplace (State o buntry) Irginia	r Foreign
within 72 hours after death with the Maryland ane. then "natural", or Iteme 23e or 28e-f ehow na Madical Exp. uner mart be notified at	_	Usual Residence of	10b. County			Town or Lo						10d. Inside Ci	
28a-f	Director	Ohio Mahoning Youngstown 10e. Street and Number 10f. Zip Code								10g. Citi;	zen of What Co		
3a or	i Dir		Varren Ave	enue			44511			-	J.S.A.	•	
n /z tiouis atter death with the maryrar "natural", or iteme 23a or 28a-1 ehow golcal Examinar mast be notified at	/ Funerai	11. Marital Status	ried 2 Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give		1	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Ame Black, Whit	e, etc.	
atural',	ted by	3 ₺ Widowed	4 Divorced 15. Decedent's Ecify only highest gra	Year or Dates:	-	16a. Dece	dent's Usual Occup	nnt's Usual Occupation				lack Industry	
	Completed	Elementary/Secr		College (1-4or 5	+) I	life. I	kind of work done of DO NOT use retired Aker	f)	Mig	Owr	Home		
stal Hygi ot other event.	BeC		(First, Middle, Last,	,				18. Mother's Nam	ne (First, Middle	. Maiden	Sumame)		
nd Mental marked o	10 E	Ernest Stanton							Sue Śta				
and Men is marke eumatic	1		lame/Relationship (**			ng Address (Street						
f Heelth and Men Item 27 is marke other treumatic	1		te Turner	(Daught	20b. Plac	ce of Dispo	astleton		pper ma.		cation - City or		
0		1 Burial 2 □ Cremation 3 □ Removal from State Green 4 □ Donation 5 □ Other (Specify) Memoria					al Gardens 4/22/06 Youngstown, Ohio 22. Name and Address of Facility L.E. Black, Phillips & Holden Funeral Home						
Dapartment Important: If any Injury or ance.		21. Signature of	uneral Service Lice	three	-	$\stackrel{\scriptstyle 22}{L}$.E. Black 951 McGud	ss of Facility c, Philli fey Rd.,	ps & Ho Youngs	lden town	Funera OH 44	1 Home 505	
nysician /Medical Examiner		shock, or he Immediate Cause disease or conditi resulting in death)	art failure. List only (Final on	plications that caused one cause on each lir a. Metasta Due to (or as	ung C		g, such as cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween	
incate be executed physicien end is the burial-transit	edical Examiner	Sequentially list of any loading to cause. Enter Und Cause (Disease of that initiated event resulting in death)	(S	c. Due to (or as									
atin certi	Physician/Med	IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2 9 □ Unknow	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	leath 3[Ectopic pregnancy Other (specify)	,		2	23d. Date of de Month		Year
ures mai me de signed by the a lid be detached l	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Hypertensive Cardiovascular Disease							37			o the cause of o	
ine law require sate has been si page 2 should t	Completed								24a. Was auto perfe 1 Yes	psy omed?	death?	utopsy findings completion of c	available ause of
ticlen: Th certificate rector, pag	Be C	25. Was case refe	erred to medical					26. Place of Dea	th (Check only	оле)		1,2110	hter
Attending Physiclen: r death. ector: After this certifics by the funaral director, i	2	1 ☐ Yes 2 2 27. Manner of Dea 1 🛣 Natural		28a. Date of Inju (Month, Da	ont 2 El ry y Year) 2	R/Outpatier 28b. Time o Injury	f 28c. Injur Wor	y at	lome 5 Res 28d. Describe		- ' '	Daug edy) Resi	denc
5 £ £ €	Certification	2 Accident 3 Suicide 4 Homicide	6 Could not b	OB Class of Ini	ury - At hom c. (Specify)	ne, farm, st					reet and Number or Rural Route Number, b, State)		nber,
To the Hospitel or At within 24 hours efter of To the Funeral Direct completaly filled in by	Medicai (29a. Certifier (Check only one)		hysician: To the best miner: On the basis of and manner sta	f examination								s)
To the Within To the somple	Me	29b. Signature an	d title of certifier	11.	-1		29c. Licens	e number		29d. Dai	te signed (Mon	th, Day, Year)	
6		Fu	ani	yltags -	hypu	wi	D28	079		Apri	1 17,	2006	
1				Shipman, M	.D. 1	11700	Print) Beltsvil	le Dr.,	#100 Be	ltsvi	11e, M	D 20705	
St Regist	tate trar	31. Date filed (Mo	APR 2	2006 32. Registr	ar's Signatu	ire	Specker						

			Please 1 - Storte Registrer	Type or Print in Bl State of Maryland	/ Depa		lealth and M	-	ygier	2 006	12490	
	Physic	ian	Registrer 1. Decedent's Name (First, Middle, Lass Thomas Marshall P		Cei	uncate of	Deain	2. Date of D		Day Year	3. Time of Death	
	/Medi Exami		4a. Facility Name (If not institution, give Fairhaven		r Location of Death	4-	1.7	-2006 4c. County of Dea Carro	th			
	Funeral Director		5. Social Security Number 6. Social Security Number 1219–18–1169	7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth ay Yea	9. Bir	thplace (State or Foreigr	
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Carro1		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 7200 Third Avenue	C-64		10f. Zip Code 21784			10g. (Citizen of What Co	ountry?	
980	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show sumatic event, the Medical Event is art must be a citized at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specific Mexican) (Specif					ecify Yes or N Rican, etc.)	city Yes or No- lican, etc.) 14. Race- Black, Specity:		- American Indian, , White, etc. White	
21215-0036	within 72 hou ane. than "nature he Medical E	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)		(Give life. L	DO NOT use retire	during most of work			Kind of Business		
Maryland 2	should be filed with and Mental Hygiene. I marked other ther umatic evant, the N	To Be Co	17. Father's Name (First, Middle, Last) John Milton Br		ACCOL	ney/busi	18. Mother's Name		e, Maide	en Sumame)	5111632	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Event art in 18 to 10th of an 2018. 2010.		19a. Informant's Name/Relationship (7 Mrs. Jean McComas 20a. Method of Disposition 1 Burial X Cremation 3	Brandt (Spouse	72.0 ce of Disponetery, cren	O Third Sition (Name of platery or other plate	1 0	4 Syke	svil		21784 Town, State	
Baltimore,	permit. P Departme Importani any injury		21. Signature of Funeral Service Licen		H7	Name and Addie	ERAL HOME e, MD 217	& CHAP	EL (Box 195)		
	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. one cause on each lina. a. Due to (or as a conseque)	Do not ente	er the mode of dyir	g, such as cardiac o	r respiratory	arrest,	73_1400	Approximate Interval Between Onset and Death	
90,	be executed ician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — See to (or as a consequent c. — Due to (or as a consequent								
. Box 687	The law requires that the death certificate be executed tile has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	eath 3	Ectopic pregnancy Other (specify)				23d. Date of deli	ivery Day Year	
rds, P.O.	quires that the signed by ald be detacted		Part II. Other significant conditions co	entributing to death but not resulting	ng in the un	derlying cause giv	en in Part I.		tobacco Yes 2		the cause of death?	
II Reco	The taw requir cate has been si page 2 should	Completed by						24a. Was auto perf 1 \(\text{Yes}		prior to death?	topsy findings available completion of cause of	
on of Vital Records,	ul or Attanding Physician: The affer death. I Director: Atter this certificate h d in by the funeral director, page	To Be	27. Manner of Death		VOutpatient Bb. Time of Injury	3 DOA Othi	4 Linursing Hor		idence	6 ☐Other (Specury occurred	cify)	
Division	To tha Hospital or Attano within 24 hours after deati To tha Funaral Director: completely filled in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	1		28f. Location (City or To			ral Route Number,	
	ha Hospital in 24 hours a ha Funaral I pletely filled	edical	29a. Certifier 1 Certifying Phy check only one)	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin estigation, in my of	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(: date ar	s) and manner as nd place, and due	stated. to the cause(s)	
	To tha within 2. To tha l	2	29b. Signature and title of certifier	M in	9	29c. License	37927		29d. D	ate signed (Month	o, Day, Year)	

State Registrar

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene (1)

Physici		1. Decedent's Name (First, Middle, Last) James T. Biv:	ins,	Sr		2. Date of Do Month 4	Day	Year 2006	3. Time of Death 10:30 P M
/Medic Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of De	<u> </u>		2000 nty of Death	
LAUIIII		Gilchrist Center		Towso			Ва	lto	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bi	rth	9. Birthpl	lace (State or Foreign
Director		216-24-8686 A ¹ XM ² □ F 74	Yrs.	Months Days	Tiours III	in. (Month, Di 7-13-	-1931	3000	Md
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Lo	ocation			<u>-</u>	10	0d. Inside City Limits
Marylan -f ehow jed et	Ď	Md N/A Bal	to						1X Yes 2 □ No
vith the Marylar or 28a-f ehow be notified at	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	of What Coun	itry?
h witi	<u>e</u>	3241 Dorithan Road		2	1215		U S	A	
within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ne Madicel Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	tispanic Origin?	(Specify Yes or No	o- 14. R	ace - America	
s afte	by Fu	1 Never Married 2♥ Married IVes, Give	-	1 ☐ Yes 2 🌠 No		, , , , , , , , , , , , , , , , , , , ,	Spec		ack
hour tural		3 Wildowed 4 Divorced Year or Dates:							
in 72 hor	Completed	(Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of v d)	vorking		Business/Ind	ity School:
filed withi Hygiene. other ther	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 4 years		eacher	-,		Darti	more c	ity Belloon
other other	0	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middle	, Maiden Sum	ame)	
uid by Menta Aenta riked	To B	James R. Bivins			Margar	et Thomas	5		
s 1 and 2 should be filed if Health and Mental Hygic Item 27 is marked other other traumatic event, II	ľ			ng Address (Street					Code)
and 2		Margaret Bivins - Wife	-	Doritha	n Road		MD 2121	5	
Jes 1 of H if iter		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Plac	e of Dispo etery, crer	osition (Name of matory or other pla	ce)	Date	20c. Location	n - City or To	wn, State
nit. Pages entment of ortent: if i injury or		4 Donation 5 □ Other (Specify) Wood		Cemetery		-25-2006		Co, M	id
permit. Pa Depertmen Importent: eny injury		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility	March Wes	st		
40200	2 0	Junelle K. Jones			4300	Wabash Av	venue B	alto,	
		23a. Part1. Enter the disease, or complications that coused the death, shock, or heart failure. List only one cause on each line.	Do not ent	ter the mode of dyli	ng, such as card	, [/	- 1	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	705	stwe	Hea	MA	Luse		jear
Examiner		Due to (or as a consequer	(ce of):					(
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):						
s be executed sicien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C							
exec en an rial-tr	Exa	resulting in death) Last Due to (or as a consequent	nce of):						
ate be executed hysicien and the burial-transi	dicai	d							
ing ph	Med	IF FEMALE:			-			49	
eath certific attending p	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	ath 3	Ectopic pregnancy	1			Date of deliver	ry Day Year
by the a	Sic	1 Yes 2 No 4 Pregnant at time of deat	h 5□	Other (specify) _					Suy Tou.
ed by detac	Ph	Part II. Other significant conditions contributing to death but not resultly	na in the u	nderlying cause gry	en in Part I	23e. Did	tobacco use co	otribute to the	e cause of death?
uires thai signed to d be det	d b	Circhoses of the	w	er			Yes 2 No	3 ☐ Proba	
w requir been si should	iete	Desheterinealitan				24a. Was	24	- Moss sutas	and finding and lable
e ja has je 2	Ę	process vi-access				- auto		prior to con death?	osy findings available apletion of cause of
. 60 0	8	25. Was case referred to medical			OS Blace of D	1 ☐ Yes eath (Check only		1 🗆 Yes	2□ No
\$ 00 10	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	VOutpatien	nt 3 DOA Oth	05	Home 5 Resi		ther (Specify	Hasair
ding Phys h. After this funeral di	L	27. Manner of Death 28a. Date of Injury 28	Bb. Time of				how injury occ		, 110 proc
를 곧 잘 걸	atio	2 Accident investigation	injury		Yes 2 □ No				
he sat	100	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	a, farm, str	eet, factory, office			Street and Nur wn, State)	nber or Rural	Route Number,
r Attendition for the first by the first	T 1								
oital or Attenurs efter deat rai Diractor: lied in by the	Certification:		dge, death	h occurred at the til	ne, date and pla	ce, and due to the	cause(s) and r	manner as sta	ated.
Hospital or Atten 24 hours efter deat Funaral Diractor: tely filled in by the	lical Cert	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	and/or inv	vestigation, in my o	pinion, death oc	curred at the time,	date and place	e, and due to	the cause(s)
ithin 24 hours effer deat the Funeral Director: ompletely filled in by the	Medical Cert	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inv	vestigation, in my o		curred at the time,		_	
To the Hospital or Attending within 24 hours efter death. To the Funerei Director: After completely filled in by the funer	edicai	(Check only 2 Medical Examiner: On the basis of examination	and/or inv	vestigation, in my o	e number		29d. Date sign	ned (Month, E	Dey, Year)
To the Hospital or Atten within 24 hours effer deat To the Funarai Diractor: completely filled in by the	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of pertifier.	and/or inv	vestigation, in my o	e number		29d. Date sign	ned (Month, E	Dey, Year)
To the Hospital or Atten within 24 hours effer deat To the Funaral Director: completely filled in by the	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	(Type,	vestigation, in my o	e number	curred at the time,	29d. Date sign	ned (Month, E	Dey, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month RIL Day 9, 2006 7:20 AM **Physician** WILMA LOUISE BOWLER /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 8. Date of Birth (Month, Day, Year) Aug. 25, 1929 If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1□M 2√F 76 Aug. Director 098-22-8539 New York Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 is marked other then "naturel", or items 23s or 28s-f show traumatic event, the Mudical Examinar must be notified at 1 Yes 2 No Parkville Baltimore MD Direct 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21234 8313 Nunley Drive Apt.A USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ð 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Private Duty Elementary/Secondary (0-12) Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any light or other traumatic event size. Be Helen Russell Harold Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8313 Nunley DriveApt.A-Parkville,MD21234 Susan Bowler-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Dulaney Valley

Memorial Gardens
22. Name and Address of Facility 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4-22-06 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee "YEVANS CHAPEL OF MEMORIES Road-Parkville,MD 21234 8800 Harford ondise 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of) 7 DAYS **Examiner** PULMONARY EMBOLI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed DEEP VEIN THROMBOSIS Due to (or as a consequence of): Physician/Medical attending to IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown cate hes been signification category. 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? death? certificate 2 □ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one tuneral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Atter Hospital or Attending 1 XNatural 5 Pending investigation after death. 1 Tes 2 No M 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Att within 24 hours after d To the Funerel Direct tilled in by 4 | Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and atifier 29c. License number 19 Thologist D34543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE. TOWNSON MARYLAND 21204 AXE, D STEVEN R. M. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Year April 2006

Physician /Medical Examiner

Funeral

Director

with the Maryland il Hygiene. . other then "netural", or items 23a or 28e-f ehow vent, the Medical Examiner must be notified at 12 should be f h and Mental h ie marked Pages 1 and 2 ment of Health a ant: if item 27 is ury or other tra permit. Page Department of Important: if eny injury or once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Records, 8 page 2 should of Vital or Attending Physician: funeral director, After death. To the Hospital or Attend within 24 hours aftar death. To the Funeral Director: A the ģ filled in

Bailer

1 - State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 4; 20 PM LOU BAILEN 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death S+ Agnes
5. Social Security Number Baltimore Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth April 1 25, 19 24 Country) 7. Age (In yrs. last birthday) 6. Sex 1 M 20 F 82 259-12-3311 Usual Residence of Decedent 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director <u>Catonsville</u> Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Ter. USA Avenue, 21228 5723 Edmondson Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√∑ No Specify: Specify: White 3 ☐ Widowed 4 反 Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cosmotology Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Cowwell Charlie Fouche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Apt. A-3, Catonsville, MD

20c. Location - City or To 2nl \$22 8 Terrell Poppell - Son 20a, Method of Disposition 1 ☐ Burial 2
Cremation 3 ☐ Removal from State Bayview Crematory 4-21-06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee P.A., 2134 Willow Spring Rd., 21222 MINU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final Loribduc 3 weeks disease or condition resulting in death) Due to (or as a consequence of): Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1-1400/4 roldism 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Didemia 1 Yes 2 No 25. Was case referred to medical examiner?
1 XYes 2 □ No 26. Place of Death (Check only one) Be Hospitaf: 1 ☐Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of fnfury 5 Pending 1 Natural SUBJECT FELL 1 ☐ Yes 2 🙀 No 106 MKNOWY W investigation 2 Cacident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5723 EDMONDSON AVE, GMTIMORE, NO 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide SIDENCE

State Registrar

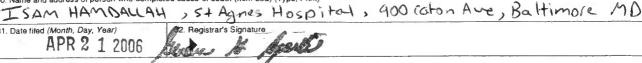
complately

31. Date fifed (Month, Day, Year) 1 2006

29b. Signature and title of certifier

29a. Certifier

Medicai



SAM HAMDALLAN, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P 19383

29d. Date signed (Month, Day, Year)

April, 20, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | For State Registra Certificate of Death Rag. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 1648 XAVIER 2006 BEL MAGIC /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL SILVER SPRING

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) CROSS MONTGOMERY HOLY Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 M 2 □ F Yrs. MARGLAND 2006 Director none Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or 28a-f show the Medical Examiner must be notified at 1 XYes 2 □ No Directo $\mathcal{Q}M$ CHITHERSBURG MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 23a 11011 SA DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? , or Items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: PUERTO RICAN Specify: BLACK ۾ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, Ite Madie 2006. Elementary/Secondary (0-12) College (1-4or 5+) none none none 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) STEPHANIE BONILLA BELL WITTHEW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HOLY CROSS HOSPITAI GLEN RD SILVER SPRING MO 20910 1500 FOREST 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 ♥Other (Specify) in state 21. Sign ture of Emeral Service icensee Ronald . Wade, Director State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. non Approximate Interval Between Onset and Death Immediate Cause (Final Physician PREMATURIT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PREVIABLE 23 WEEKS Sequentially list conditions, if any lauring to immediate cause. Enter Underlying Cause (Disease or injury Due to [or as a consequence of] Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by PREMATURE RUPTURE OF MEMBRANES 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physicien: : After this certification, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of certifier 29d. Date signed (Month. Dav. Year) 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

2101 MEDICAL NANCY BEHRAM WD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

ORIGINAL

PARK DR

#307 SILVER SPRING MD 20902

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 605 PM CLUBB CIPRIL MAUREEN 2006 19 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE MD

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Davs Hours Min. Sept. Day, Year 9 4 0 JOHNS HOPKINS BAYULEW Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 XF 65 216-30-2131 MAryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show traumatic event, the Medical Examiner must be notified at Middle River MD Baltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21220 USA 1314 Third Road Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Madical Examiner must. once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Moran William Sann ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21221 265 Southeastern Terrace Balto. MD Mark Hepding /son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Sacred Heart of Jesus 4/22/06 Baltimore MD Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Heart **Physician** ongestive +ailure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** reast Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ol) Examine use as the burial-transit Attending Physician: The law requires that the death certificate be executed Puluonary Di Sease that initiated events resulting in death) Last ettending physiclen end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown After this certificate has been signed by funeral director, pege 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year, 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending thours after death.

uneral Director: After a property of the function of the 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō within 24 hours a 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Lean Nalul 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOPKINS DALIL N.O DEAN 31. Date filed (Month, Day, Year) 32. Pogistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 A M APRI 2006 /Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATION Year If Under 24 Hrs. 8. Date of Birth Pays Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ YM 2 □ F Months Days 216-10-4429 91 Director Mď March 12 1915 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. or items 23s or 28s-1 show int: if Item 27 is marked other than "naturel", or items 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or iteme 23a or 28a-f shov treumatic event, the Madical Examiner must be notified at MdCarrol1 Mount Airy Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4101 Old National Pike 21771 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: Specify:white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) grocer grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Cerniglia Angela 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 item 27 other tre Rosemary Clatworthy (daughter) 1630 Church St., Glen Rock, PA 17327 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent; if it any injury or o 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Memorial 4-24-06 Sykesville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Jage Haight of Cupur P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to for as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events by Physician/Medical Examiner for use as the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg is certificate has been si director, page 2 should i Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 1 ☐ Yes 2 ☐ No 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

Inerei Director: After this y filled in by the funeral di 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Z Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a r Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

ANNADON 12

9521 Old

Noob 32. Reastrar's Signature

of death (Item 23a)

29d. Date sign

RYY

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 6:55 PM April 2006 SURLFAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name If not institution, give street and number) Sna of Baltimore Baltimore Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Oate of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) 6. Sex 5. Social Security Number Months Hours Days 1 ☐ M 2 🗙 F 218-42-1145 Usual Residence of Decedent NORTH CAROLINA 10c City Town or Location 10d. Inside City Limits 10h Count 10a State BALTIMORE CI 1 Yes 2 □ No MARYLAND NIA 10e. Street and Number 100 Citizen of What Country? 542 21215 14. Race - American Indian, Black, White, etc. AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status 1 Never Married 2 Married Specify: BLACK 1 Tes 28 No Specify. 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) THGRADE SELF-EMPLOYED ARETAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILKERSON LEE WILLIAMS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5424CRISMER FRANCINE JOHN SON (DAUGHTER) BALTIHORE MD. 2/2/5

20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition t⊠ Burial 2 □ Cremation 3 □ Removal from State BALTO. NAT'L CEME. 104-24-06 BALTIMORE 4 Donation 5 Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MO. 21217 21. Signature of Funeral Service Licens 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sessis disease or condition resulting in death) Due to (or as a consequence of) Respiratory Distress Syndrame Due to (or as a consequence of): Disseminated

Pnysician /Medical Examiner

burial-transit

been signed by the attending physician should be detached for use as the buria

spltal or Attending Physician: Theoris after death.
Ineral Director: After this certificate y filled in by the funeral director, pa

To the Hospital o within 24 hours aff To the Funeral Di

Division of Vital Records, P.O. Box 68760

Examine

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State Registrar

Physician

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Examiner

Funeral

Director

or 28a-f show

the Medical Examinar must be notified at

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other then any Injury or other traumatic event, the May once.

Baltimore, Maryland

filed within 72 hours after death 1 Hygiene.

Director

Funeral

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Sequentially list our ditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the desired examples) that initiated events resulting in death) Last

Due to (or as a consequence of)

Renal Acute 23d. Date of delivery Year

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

Month Dav

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No

Hypercholesterolemia

5 Pending

investigation

24a Was an autopsy performed? 2□No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical 212 No 1 🗌 Yes 27. Mannes of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000

Hospital of Beltimore

April 17, 2006

31. Date filed (Month, Day, Year)

Dinai 32. Registrar's Signature

2006

DHMH 17 Rev 1/200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Amend Item #20c Per FH G855 Spatificate of Death 3. Time of Death 2. Date of Death April 16, 2006 Par **Physician** 23:30 Clark Jeannette H. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F Yrs. Director Jan. 19, 1907 | Maryland 218**-**14-6**7**58 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f shov othar traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Harford Bel Air Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 120 South Parkway 21015 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Health Care 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Holland Sarah (nmn) Frazier William J. permit. Pages 1 and 2 st Department of Health and Important: If item 27 is main eny injury or other irrange. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4414 Norrisville Road, White Hall, Maryland 21161 Peggy Era -Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St.John's Episcopal 4 ☐ Donation 5 ☐ Other (Specify) 4/20/2006 Kingsville, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fewere. List only one cause on each line 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Drodenal bleed /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1√0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

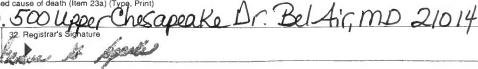
State Registrar

DHMH 17 Rev 1/2001

lark, Jeannette#80356654

31. Date filed (Month, Day, Year)

APR 2 1 2006



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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 63138

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | 1 - Stata Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ,2006 /Medical William Douglas Hardy 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Levindale Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 XM 2 ☐ F Director 223-32-7319 75 Yrs. 30 04 20 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r itema 23a or 28a-f show 10d. Inside City Limits Director MD Baltimore Pikesville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7915 Crisford Place Apt D 21208 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1√Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Š Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Heavy Machine Operator Dept. Of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental Hitam 27 Is marked oth Be 2 William Hardy Gertrude Edmonds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 l Shirley A. Hardy-Wife
20a. Method of Disposition 7915 Crisford Place Apt D. Baltimore. Pikesville, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) ≒ ö Owings Mills, Md Garrison Forest 4/21/06 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md. 21215 23a. Part. Enter the intease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Bladder Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under yin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 Yes or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No i after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

Division of Vital

2006 DHMH 17 Rev 1/2001

Wellamo 32 Registrar's Signature

30. Name and address, of person who completed cause of death (Item 23a) (Type, Print)

Belveder Ave, Bulto. Ad ZIZIS

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1355 **Physician** 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ F 92 Baltimore, Maryland December 24, 1913 Director 213.05.6228 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than *netural', or items 23a or 28a-f show any injury or other traumatic event, ir a Madical Exercitiner roust be notified at once. 1 Yes 2 No Ellicott City Directo Howard Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 2517 Melba Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 □ No If Yes, Give 194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1943 White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 ☐Widowed 4 ☐ Divorced Year or Dates: 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) industria College (1-4or 5+) Elementary/Secondary (0-12) Mechanic 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Horvath Joseph Engelberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2517 Melba Road Ellicott City, Maryland 21042 Daughter Ms. Ellen Dana Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Spentry) Gaithersburg, Maryland 04/24/2006 Oak Forest Cemetery e of Fune al Service 22. Name and Address of Facility Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final dise e or condition Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 5 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by sign 3 ☐ Probably 4 ☑ Onknown 2 □ No 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an cate has l autopsy performe 1 Yes 2 INO certificate To the Hospital or Attending Physicien: After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other. 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) ^oL 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Certification: 1 Natural 5 Pending 2 No 1 Yes investigation hours after death. 2 Accident Director: 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours at To the Funerel D Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Radical Examiner: On the basis of examinuting and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed, (A) 29b. Sign war an Name and address of berson who comp MEINH JOB! 31. Date filed (Month, Day, State Registrar